Bryan Cloe DDS & Patrick Kennedy DDS
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HIPAA RELEASE FORM

Patient name: _____ Date of Birth: ___/____/_____

LEGAL RESPONSIBILITY check the box below that applies:

- ☐ If you are 18 years or older, you are a legally responsible for yourself.
- ☐ If you are an emancipated child or teenager and your parents no longer have custody over you.
- ☐ If you are a parent or legal guardian who has primary custody of the patient
  Parent/Guardian Name:

RELEASE OF INFORMATION

[ ] I authorize the release of any and all information, including treatment plans, diagnosis, dental records (photos, x-rays) and claim information. This information can be shared with healthcare professionals, family members, pharmacies, and insurance companies.

[ ] I do not authorize the release to: _____

This ***RELEASE OF INFORMATION*** will remain in effect until terminated by myself in writing.

CONTACT

Preferred way of contact: [ ] CELL PHONE [ ] HOME PHONE [ ] EMAIL [ ] TEXT

Please provide preferred contact information: _____

If unable to reach me: [ ] please leave a detailed message

[ ] please leave a message asking me to return your call

I understand that this office will try to accommodate my wishes on preferred method of contact, but may have to contact me in other ways if unable to be reached.

PHOTOS

[ ] I authorize Dr. Cloe and Dr. Kennedy and his staff to take any necessary photos with intraoral cameras, cellular phones or iPad, as they see fit to retrieve the best diagnostic picture they can.

DEPENDENTS

Please list the names of your dependents below if you wish to include them; with the understanding that the same will apply to them until they are the age of 18 or emancipated.

_____

_____

_____ _____

Patient Name & Signature Date