HIPAA Release Form &
Patient Acknowledgement of Notice of Privacy Practices

Your privacy, including the confidentially of your health information, is very important to us. Additionally, Federal Law prohibits the unauthorized release of certain medical and health information. Before our office can use your protected health information for treatment, payment and health care operations, you must acknowledge that you have received and read our Notice of Privacy Practices informing you how our office may use and disclose your Protected Health Information.

By signing this form, you acknowledge that you have read our Notice of Privacy Practices concerning the use and disclosure of your Protected Health Information.

1. ( ) I consent to the release of verbal information regarding my diagnosis/test-results/treatment plan to:

( ) My spouse: _____

( ) My children: _____

( ) My family members: _____

( ) Other: _____

2. ( ) I authorize Franklin Dental to leave dental information on my voicemail, answering machine, text and/or e-mail

_____

Email Address

_____

Print Name of Patient/ Legal Guardian

_____ _____

Signature ***Date***