DENTAL INFORMATION RELEASE FORM
(HIPAA Release Form)

Name: _____ Date of Birth: _____

Release of Information

[] I authorize the release of information including the diagnosis, records, examination and claims information. This information may be released to:

[] Spouse _____

[] Child/ Children _____

[] Other _____

[] Information is not to be released to anyone.

The Release of Information will remain in effect until terminated by me in writing.

For Messages

Please call: [] my home [] my work [] my cell number

If unable to reach me:
[] you may leave a detailed message
[] please leave a message asking me to return your call
[] _____

The best time to reach me is (day) _____between (time)_____

Signature _____ Date: _____