Dental Information Release Form

(HIPAA Release Form)

Name: _____ Date of Birth: _____

Release of Information

☐ I authorize the release of information including the diagnosis, billing information, appointment times, records, proposed treatment, examination rendered to me and claims information. This information may be released to:

- ☐ Spouse _____
- ☐ Children _____
- ☐ Parent(s) _____
- ☐ Other _____

☐ Information is not to be released to anyone.

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

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
- ☐ you may text me detailed information
- ☐ you may text me asking me to return your call
- ☐ _____

The best time to reach me is: _____

Signed: _____ Date: _____

Witness: _____ Date: _____