HIPAA RELEASE FORM

I,_____, authorize the release of information on
(PRINT PATIENT / GUARDIAN NAME)

_____, including the diagnosis, records, examination and
(PRINT PATIENT NAME)
treatment rendered to above patient, ledger and billing, and claims information.

This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone. (Initial Here)_____

In further consideration for this, Justin Family Dentistry agrees to the same stipulations.

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

Messages and communication from our office

If we are unable to speak directly to you concerning matters pertaining to your care, please check one of the following preferences

[ ] you may leave a detailed message

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

[ ] other_____

The best phone number to reach me at is:_____

Signed: _____ Date: _____/_____/_____

Witness:_____ Date: _____/_____/_____