A.Y. Family
DENTAL

HIPAA Medical Information Release Form

Name:_____Date of Birth:_____/_____/_____

Release of Information

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

[ ] Spouse_____

[ ] Child(ren)_____

[ ] 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 _____

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/night)_____ between(time)_____

Signed:_____ Date:_____/_____/_____

Witness:_____ Date:_____/_____/_____