PATIENT CONSENT FOR RELEASE OF MEDICAL INFORMATION

Due to the HIPAA laws that are now in effect we must have your written authorization to release your medical information to a person other than yourself. Understand that your information may need to be discussed with your current physician and/or referred to/or/ from specialists in regards to scheduling of procedures, consultations and health history that may impact your dental health. Only the information needed to do this will be released. This release will be valid for one year from the date of signing.

1. Who may we release your medical information to:

   A) Spouse___________ B) Sibling___________ C) Parent______________

   D) Son/ Daughter_______________ E) Other) _________________________
   Please give name of person

   F) Doctors Office____________ F) Insurance Company________________

2. May we send reminder postcards through the mail and or e-mail?

   Yes_____________ No________________

3. May we leave a message on your answering machine, text or by e-mail to confirm a dental appointment?

   Yes______________ No_________________

Print Pt. Name _______________________ Signature___________________________

Date ____