

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 dental appointments, discuss dental treatment and account balance ?

Yes _____ No _____

Print Pt. Name _____ Signature _____

Date _____