HIPAA Disclosure Form

Dental Office: ________________________________ Doctor: ________________________________

Patient Name: ____ Date: _____________

Listed Address: ____

Preferred Correspondence Address: ____

Listed Phone Number: ______________________ Preferred Phone Number: ________________

Listed Email Address: ____

Preferred Email Address: ____

Would you like out correspondence with you to be marked “Confidential”? ___ Yes ____ No

May we identify ourselves over the phone? ___ Yes ___ No May we leave a message? ___ Yes ___No

I, _______________________________, hereby authorize the doctor and/ or office above to release my medical information (appointments, lab/x-ray results, diagnoses, treatments, medications, surgeries, ect.) via postal mail, telephone, fax or email to the following family members:

Name: ____________________________ DOB: _____________ Relationship: ____________________

Name: ____________________________ DOB: _____________ Relationship: ____________________

Name: ____________________________ DOB: _____________ Relationship: ____________________

Name: ____________________________ DOB: _____________ Relationship: ____________________

Name: ____________________________ DOB: _____________ Relationship: ____________________

I further release my medical information to the following physicians, clinics, and/or hospitals:

Doctor: ___________________________ Clinic: ___________________ Phone: __________________

Doctor: ___________________________ Clinic: ___________________ Phone: __________________

Doctor: ___________________________ Clinic: ___________________ Phone: __________________

Doctor: ___________________________ Clinic: ___________________ Phone: __________________

Doctor: ___________________________ Clinic: ___________________ Phone: __________________