HIPAA AUTHORIZATION AND RELEASE FORM

Patient Name:_____ DOB:_____

Release of Information

[ ] I authorize the release of all information including but not limited to my personal health information on file with Miller Family Dental. This may include: diagnosis of treatment needs, dental records, examination records, x-rays, appointment information, insurance information and billing information. This information may be released to:

[ ] Parent/ Spouse _____

[ ] Child(ren): _____

[ ] Other _____

[ ] Information should not be released to anyone.

Please specify any particular requests in relation to the release of your information to the above listed individual(s):

_____

_____

I understand that this release will stay in effect until I revoke it in writing. I may revoke this release in writing at any time.

_____ _____

Print Name Signature

_____

Date

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