Highland Family Dental Care

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AUTHORIZATION FOR RELEASE OF INDENTIFYING HEALTH INFORMATION

Patient(s) Name: _____
Patient Address: _____
Patient Phone Number: _____
Patient(s) Date of Birth: _____

I authorize Highland Family Dental Care to disclose identifying protected health information. I understand that the person(s) listed in this form below have been authorized be myself to receive information about myself as specifically stated in the form below. I understand that by leaving the below section incomplete that Highland Family Dental Care does not have my permission to discuss any of my identifying protected health information with any persons not authorized in this form or verbally consented to. I understand that Highland Family Dental Care is legally obligated and will notify me of their required release of my identifying protected health information to release certain information without my permission as stated in their HIPPA Notice of Privacy Practices to certain federal agencies. Highland Family Dental Care cannot withhold treatment of a patient unwilling to sign this form. I understand that at anytime I can revoke the right to release information by giving right documentation in doing so.

1. I authorize Highland Family Dental Care to disclose identifying protected health information to the following person(s):

2. I authorize Highland Family Dental Care to disclose identifying protected health information of the following information only:

3. I authorize Highland Family Dental Care to disclose identifying protected health information during the time frame of:

I am allowing Highland Family Dental Care to release detailed information to myself and the above listed person(s) by:

phone message _____(Initial) email _____ (Initial)

I have read and understand this form. I understand that Highland Family Dental Care is legally obligated by Federal Laws as stated in the HIPPA Notice of Privacy Practices. By signing this form I have given Highland Family Dental Care permission only to release information to the person(s) listed above.

Date: _____ Patient/Parent/Guardian Signature: _____

If the patient is a minor:

Parent/Guardian Name: _____Signees: Relationship to Patient: _____
Printed