GENERATIONS
FAMILY DENTAL
Est. 1962

Medical/HIPAA Information Release Form

Name: _____ **Date of Birth:** _____/___/_____

Release of Information

☐ I authorize the release of information, including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

- ☐ Spouse _____
- ☐ Child(ren) _____
- ☐ Other _____
- ☐ Information is not to be released with anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call my home my work my cell number: _____

If unable to reach me:

- ☐ You may leave a detailed message.
- ☐ Please leave a message asking me to return your call.
- ☐ _____

The best time to reach me is (day) _____ between (time) _____

Signed: _____ **Date:** _____/___/_____

Witness: _____ Date: _____/___/_____