HIPAA Release Of Information Form

Name: ______________________________ **Date of Birth:** _______________

[ ] I authorize the office of Destin Harbor Dental to release information including; dental treatment(s), records, financial information, and appointments. This information may be released to…

[ ] Spouse ____

[ ] Child(ren) ____

[ ] Other ____

[ ] Information is not to be released to anyone.

This ***Release Of Information*** will expire 1 year from the date signed.

Messages

If unable to reach me:

[ ] You may leave a detailed message

[ ] Please leave a message only asking me to return your call

[ ] Other ____

Patient Signature: _____________________________ **Date**: __________