Patient Name: ____
(Please Print)

HIPAA Privacy Authorization Form

Privacy regulations require us to have releases signed by our patients for us to speak with family members, friends, and other relations regarding dental treatment. Each person must be listed individually and by name

Please check each box for the information you would like to share and print name, relationship, and telephone number for each person to whom you are authorizing release of your private dental care information.

- ☐ Dental Records
- ☐ Treatment Records
- ☐ Diagnostic Records
- ☐ Financial Records
- ☐ Other(s): ____

- ☐ I do *not* give permission to release my information.

Name	Relationship	Phone Number
______________________________	________________	______________
______________________________	________________	______________
______________________________	________________	______________
______________________________	________________	______________

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have read and understand this office’s Notice of Privacy Practices.

Patient Signature: ____ **Date:** ________