

**Medical Information Release Form
(HIPAA 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 _____ Date of Birth: ____/____/____

Child(ren) _____ Date of Birth: ____/____/____

Other _____ Date of Birth: ____/____/____

Information is not to be released to 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:

send text or email Email: _____

you may leave a detailed message

Notice of Privacy Practices

I acknowledge that I received a copy of Emerald Family Dental's Notice of Privacy Practices.

Signed: _____ Date: ____/____/____