



Personal Health Information Release Form
(HIPAA Release Form)

Name: _____ Date of Birth: ____/____/____

Release of Information

I authorize the release of any and all information including the diagnosis, financial and dental records; examination rendered to me and claims information. This information may be released to:

- Spouse _____
- Child(ren) _____
- Other _____
- 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 the following number:

my home: _____ my work: _____ my cell: _____

If unable to reach me:

- please leave a detailed message
- please leave a message asking me to return your call
- _____

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

I understand that this office will try to accommodate my wishes about my contact information, but may have to contact me at the other numbers if unable to contact me at my requested number/location.

Signed: _____ Date: ____/____/____



Authorization for Release/Use of Protected Health Information In the Form Of Photos, Radiographs, and Electronic Images

Your photos and x-rays are part of your diagnostic and clinical record and are considered to be protected health information under federal HIPAA Privacy Laws.

We make use of radiographs (x-rays), photographs, and digital images. These images may be used for diagnosis, documentation, reference, teaching, and research publication. Some cases that present exceptional results, particularly remarkable smiles, or interesting situations may be utilized for demonstration, education or advertising to potential and existing patients in our office either in print media, television, on digital media and on our webpage. In some instances, you may be recognizable in some of these images. By initialing and signing this form, you are authorizing us and releasing us from any liability resulting from the use/release of such images. Your authorization and release to use images will in no way affect the quality of your results in our office. We do our best to provide exceptional dentistry to all patients.

- I authorize the use of my images where my face is identifiable
- I authorize the use of my images where only my teeth are identifiable
- I authorize the use of my radiographs
- I do not authorize the use of my images or radiographs

The purpose of this request to release and/or disclose the PHI described above is for personal reasons. I understand that I have the right to revoke this Authorization, in writing, at any time by notifying the office above. Such revocation will not affect actions taken by the requesting person prior to the date he or she received the written revocation. I also understand information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and will no longer be protected by this rule.

I understand that my health care provider cannot condition treatment on whether I sign this Authorization. This Authorization will expire at such time that:

- I determine that I no longer wish for my images to be used and I revoke this authorization in writing; or
- The following date: _____ (within one year of current date).

Signature of Patient

Date