SEDATION DENTISTRY of CHARLESTON

HIPAA Release Form

Patient Name: _____ DOB: _____

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 to anyone

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

Best number to contact me: _____

- Home
- Mobile
- Work

If unable to reach me:

- You may leave a detailed message
- Please leave a message asking me to return your call
- Do not leave a message

Signature: _____ **Date** _____