Morfas Family Dentistry

Medical Information Release Form

HIPAA Release Form

Name:_____Date of Birth:____/____/____

( ) 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_____

( ) Other Healthcare Provider_____

( ) Information is NOT to be released to anyone.

Please call: ( ) my home ( ) my work ( ) my cell number:_____

If unable to reach me: ( ) you may leave a detailed message.

( ) please leave a message asking me to return the call.

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

Signed:_____Date:____/____/____

Witness:_____Date:____/____/____