Dental Patient HIPAA Release Form

Patient Information

Patient Name

Date of Birth

Phone Number

Release of Information

Name(s) of person(s) or organization(s) to receive information

Relationship to Patient

Information to be Released (please specify)

Purpose of Release

Expiration Date or Event

- [ ] I understand that I have a right to revoke this authorization at any time.

Patient Signature

Date

If signed by a personal representative, relationship to patient