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HIPAA RELEASE FORM

Authorization to Release Records

Privacy regulations require us to have a release signed by our patients so we may speak with family members, friends and other relations regarding your dental treatment and patient financial information. Each person you wish to be considered a contact must be listed individually by name (including a Spouse or Significant Other).

Please print name, relationship and telephone number for each person to whom you are authorizing release of your private health care and account information.

Name	Relation	Phone Number

Patient Name (print)_____

Patient/Guardian_____ Date_____