CitySmiles
Family Dental Practice

Patient Record of Disclosure
(HIPAA Release Form)

Patient's Name: _____ Date of Birth_____ /_____ /_____

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

□ Primary Telephone: _____

- □ OK to leave voicemail with detailed information
- □ OK to leave message with family member
- □ Leave message with call-back number only

□ Secondary Telephone: _____

- □ OK to leave voicemail with detailed information
- □ OK to leave message with family member
- □ Leave message with call-back number only

□ Email: _____

- □ OK to send email with detailed information
- □ Leave message with call-back number only

□ Other (Any non-legal guardian, SPOUSE, family member, co-worker, etc. you give authorization for us to speak to)

_____

I authorize the following information to be released to the above parties:

□ Exam Notes □ Diagnosis □ Treatment Notes □ Claims and Billing

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

Signed: _____ Date: _____