Medical Information Release Form (HIPAA Release Form)

Name:_____ **Date of Birth:**_____/____/_____

Release of Information

□ **I hereby authorize** Sarah Clayton, DDS and affiliates, employees , or agents to release any personal health information (e.g., information relating to the diagnosis, records, treatment, claims payment, and health care services) provided or to be provided to me to:

[ ] Parent/ Spouse / Relative_____

[ ] Referring Provider _____

[ ] Primary Care Doctor_____

[ ] Other Consultants_____

_____
[DESCRIBE INFORMATION NOT TO BE DISCLOSED, IF ANY]

□ **I do not authorize** Sarah Clayton, DDS or affiliates to release any medical information.

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

Messages

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 your call

[ ] _____

The best time to reach me is (*day*)_____between (*time*)_____

Signed:_____Date:____/____/_____

Witness:_____Date:____/____/_____