HIPAA Release

I,_____, authorize the release of **ALL** my HIPAA protected information to:_____
I understand that this includes financial, scheduling, and medical information. I also understand that I may alter this declaration by submitting a written request. I authorize the above person(s) to make scheduling, treatment, and financial arrangements on my behalf.

☐ I authorize Fenton Family Dentistry to leave a message regarding any of my financial, scheduling, and medical information.

Phone number:_____

☐ I authorize Fenton Family Dentistry to email any of my financial, scheduling, and medical information.

Email:_____

☐ I do not wish to share any of my HIPAA protected information with anyone.

I understand that I will still be financially responsible for any treatment performed, or products supplied to me.

Signature:_____ Date:☐☐/☐☐/☐☐

Parent or legal guardian signature if the patient is a minor