Authorization for Release of Protected Health Information
Health Information Communication Methods

(HIPAA RELEASE)

We can only disclose your protected healthcare information under the terms of the HIPAA polices. If you wish to grant any person besides the patient or responsible party listed on our patient information forms to have access to your protected health information please indicate below.

Patient Name _____ DOB_____

Responsible Party_____

RECORDS

Check all that apply	Type of Health Information
	Dental Treatment Records
	Medical Records
	Appointment Records
	Insurance Records
	Referral Records
	Billing Statements
	Contact Records

TO

Name	Relationship to Patient

COMMUNICATION

Please indicate the forms of communication that are acceptable to use for the patient, responsible party, or any persons indicated for release. Anyone you listed in the above section to release information to needs to be listed in this section. Only fill in the information asked if you are consenting to contact the person by the means indicated.

Name	**Address**	**Cell Phone**	**Home Phone**	**Work Phone**	**Email Address**	**Please list preferred method of contact**

Do we have permission to leave a message on home/cell voicemail for numbers listed? ☐ *Yes* ☐ *No*

Do we have permission to leave a message on work voicemail for numbers listed? ☐ *Yes* ☐ *No*

EXPIRATION

	This authorization has no expiration unless I provide a written termination request as well as sign and date a new authorization form
	This authorization will expire on

I, _____

(PLEASE PRINT CLEARLY)

Hereby authorize Koren Dental Management, Inc., and please check all offices that apply:

☐ Smithfield Family Dentistry ☐ Creedmoor Family Dentistry ☐ Leland Family Dentistry

☐ Pittsboro Family Dentistry ☐ Roxboro Family Dentistry

to release the Protected Health Information and utilize indicated methods of communication as specified above.

Submit By Email

_____ _____

Signature of Patient or Responsible Party Date