HIPAA Release Form

Buchwald Family Dentistry & Orthodontics

I, _____, authorize the release of information of
(PRINTED PATIENT/GUARDIAN NAME)

_____, including the diagnosis, records, examination &
(PATIENT NAME)

treatment rendered to above patient, ledger and billing, and claims information.

This information may be released to (check one, or more, and write their first and last name):

[ ] Spouse _____

[ ] Child(ren) _____

[ ] Other _____

[ ] Information is not to be released to anyone. (Initial here) _____

In further consideration for this, Buchwald Family Dentistry & Orthodontics agrees to the same stipulations. This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages and communications from our office:

If we are unable to speak directly to you concerning matters pertaining to your care, please check one of the following preferences:

[ ] You may leave a detailed message.

[ ] Please leave a message asking me to return your call.

[ ] Other _____

The best phone number to reach me at is: _____

I am OK with receiving electronic communication via (initial below)

_____ Text Messaging

_____ Email

_____ _____/_____/_____

Patient Signature **Date**