



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

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

TO

<u>Name</u>	<u>Relationship to Patient</u>

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.

<u>Name</u>	<u>Address</u>	<u>Cell Phone</u>	<u>Home Phone</u>	<u>Work Phone</u>	<u>Email Address</u>	<u>Please list preferred method of contact</u>

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.

Signature of Patient or Responsible Party

Date