Authorization to Release Information Form

In compliance with HIPAA guidelines, a patient requesting part or all of their dental record be released to another person, (treatment plan, x-rays, test results, etc) must give consent for Giroux Prosthodontics & General Dentistry, PC to do so on their behalf. This authorization may be revoked at any time.

I, ____ authorize Giroux Prosthodontics & General Dentistry, PC to release my records and/or any information pertaining to my dental treatment to the following individual(s)

1. ______________________________________Relation: _____________________________

2. ______________________________________Relation: _____________________________

3. ______________________________________Relation: _____________________________

Authorization Regarding Messages

(please check all that apply)

__ I authorize Giroux Prosthodontics & General Dentistry, PC to leave a detailed message on my home or cell phone number regarding appointments.

__ I authorize Giroux Prosthodontics & General Dentistry, PC to leave a detailed message on my home or cell phone number regarding dental treatment, test results, or financial information.

__ I authorize Giroux Prosthodontics & General Dentistry, PC to leave a message regarding my appointment with anyone who answers the home or cell phone number on record.

____ ________________________

Patient Printed Name Date

____

Patient Signature

__ I do not authorize Giroux Prosthodontics & General Dentistry, PC to release my dental information.