Medical Information Release

I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

Name: ______________________________ Relationship: _________________________________

Name: ______________________________ Relationship: _________________________________

Name: ______________________________ Relationship: _________________________________

Or ☐ Information is not to be released to anyone.

*This **Release of Information** will remain in effect until terminated by me in writing.*

X_________________________________

Patient Name (please print)

X_________________________________ ____________________

Patient Signature **Date**

Hohenstein & Schwartz, PLLC

Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

I acknowledge that I have received a copy of this Dental Practice's HIPAA Notice of Privacy Practices. **Please Note: It is your right to refuse to sign this Acknowledgement.**

X_________________________________

Patient Name (please print)

X_________________________________ ____________________

Patient Signature **Date**

*Authority of Personal Representative to sign for Patient (check one) if applicable:

☐ Parent ☐ Guardian ☐ Power of Attorney ☐ Other: _______________________

_________________________________ __________________________________

Printed name of Personal Representative **Signature of Personal Representative**