WESTSIDE DENTAL
50 AUERT AVE
UTICA, NY 13502
PHONE: 315-266-0000 FAX: 315-266-0126

MEDICAL INFORMATION RELEASE FORM
(HIPAA RELEASE FORM)

NAME: _____ **DATE OF BIRTH**: _____/_____/_____

RELEASE OF INFORMATION

( ) I AUTHORIZE THE RELAESE OF INFORMATION INCLUDING THE DIAGNOSIS, RECORDS; EXAMINATION RENDERED TO ME AND CLAIMS INFORMATION. THIS INFORMATION MAY BE RELEASED TO:

( ) SPOUSE _____

( ) CHILD(REN) _____

( ) OTHER _____

( ) INFORMATION IS NOT TO BE RELEASED TO ANYONE.

THIS RELEASE OF INFORMATION WILL REMAIN IN EFFECT UNTIL TERMINATED BY ME IN WRITING.

MESSAGES

PLEASE CALL ( ) MY HOME ( ) MY WORK ( ) MY CELL PHONE: _____

IF UNABLE TO REACH ME:

( ) YOU MAY LEAVE A DETAILED MESSAGE

( ) PLEASE LEAVE A MESSAGE ASKING ME TO RETURN YOUR CALL

( ) OTHER _____

THE BEST TIME TO REACH ME IS (DAY) _____ BETWEEN (TIME) _____

SIGNATURE: _____ DATE: _____/_____/_____

WITNESS: _____ DATE: _____/_____/_____