dental partners of Vero Beach
Conway & Schwibner

3755 7th Terrace · Suite 303
Vero Beach Florida, 32960
772.569.4118
www.verobeachdentist.com

NOTICE OF HIPAA PRIVACY PRACTICES
Dental Information Release Form

The HIPAA Privacy Rule (The Health Insurance Portability and Accountability Act) establishes national standards to protect individuals' medical records and other personal health information.

Name: _____ Date of Birth _____

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

	Name	Contact Number
❑ Spouse:		
❑ Children:		
❑ Other:		
❑		

❑ Information is not to be released to anyone

The release of information will remain in effect until terminated by me in writing.

Please contact me in the following way:

❑ Home #: _____
❑ Cell #: _____
❑ Work #: _____
❑ E-Mail: _____

If unable to reach me:
❑ You may leave a detailed message
❑ Please leave a message asking me to return your call

The best time to reach me is (day) _____ Between (time) _____

By signing this form, I acknowledge that I have read the Notice of HIPAA Privacy Practices. I have had a chance to ask questions which were answered to my satisfaction. I understand my rights pertaining to HIPAA and sign this agreement for myself or for a patient that I am in the care of (minor or individual that requires POA).

Signed: _____ Date:_____

Witness:_____ Date:_____