dental partners of Vero Beach

Comprehensive Dentistry
Airway Orthodontics
& Sleep Solutions
For Patients of All Ages

HIPAA Records Release Consent

Name: _____ Date of Birth _____

Release of Information

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.

Messages

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) _____

Signed: _____ Date:_____

Witness:_____ Date:_____

1/2024

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