

Medical Information Release Form

(HIPAA Release Form)



San Antonio
ENDODONTICS

Patient 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:

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 number _____

If unable to reach me:

You may leave 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: / /

Drs. David Cloutier, James Ball, and John Yaccino