

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: _____ / _____ / _____

David L. Cloutier, DMD & Associates

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