Account Release Form – HIPPA

Because we respect your privacy and follow the laws of the Health Information Privacy Act, inform us, by checking the box below, who we may share private medical/dental information about you as well as account status, and treatment recommendation and outcomes regarding you and or your dependents.

Please list any persons **that are allowed** to have access to your information: Account/Personal

1) ______________________________
2) ______________________________
3) ______________________________

Please list any persons **that are not allowed** to have access to your information: Account/Personal

1) ______________________________
2) ______________________________
3) ______________________________

I understand that if Dr. Bonin's has been asked to file dental insurance for me, all diagnosis's, problems, treatment recommendations, medical/dental issues will need to be revealed to that insurance company in order for them to consider the claim. I give permission to Dr. Bonin and his staff to release any and all information about you in this instance.

Print name: ______________________________

Signature (Self/Guardian):______________________________

Date: ______________________________

Witness: ______________________________

Date: ______________________________