PETER R. BROWN, D.M.D.
3 KACEY COURT • SUITE 202 • MECHANICSBURG, PA 17055 • 717-766-5766

Dental Information Release Form
(HIPAA Release Form)

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_(Name and phone #)___________________________________
[ ] Child(ren)Name and phone #)__________________________________
[ ] Other (Name and phone #)_____________________________________
[ ] 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 a detailed message
[ ] please leave a message asking me to return your call
[ ] ____

The best time to reach me is (day)___________________ between (time)_________

I, _____________________________ , have received and understand the "Notice of Privacy Practices".

Signed: _______________________________________ Date: ____/____/_____

Witness:_______________________________________ Date: ___/____/______