Hilliard Advanced Dentistry
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Hilliard, OH 43026-1442
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(614)876-8766
Hilliarddentist@yahoo.com

PATIENT'S REQUEST FOR RELEASE OF DENTAL INFORMATION

I would like to allow the following person(s) access to my protected health information. I understand that to change this request I must make a request to this office to do so. Such requests should be made in writing and signed. Verbal requests may be allowed if followed up by a written and signed request.

You must return this signed form to us by mail, email or fax: 614-876-8804.

Patient Name:

Last | First | MI | Preferred Name

Address:

City | State | Zip Code

Phone:

Home | Work | Ext | Mobile

Best time to call:

* ☐ By checking this box, I acknowledge that I have read this statement and agree to the contents.

Name of patient, parent, or guardian completing this form:

*

Relationship to patient:

*

Response Date: