D. Keith Jones, DDS - HIPPA Restriction Form
(Health Information Privacy Portability Act)

Your privacy is important to us, and as such we will not release your dental information to anyone without your written and/or verbal consent. This may include, but is not limited to, dental treatment information, financial questions, telephone calls made on your behalf, and/or picking up any sample/products we may have for you. In order for this process to run smoothly, please list below who you will allow access to your information.

May we speak with your pharmacy regarding your prescriptions? ☐ **Yes** ☐ **No**

May we speak with your insurance company regarding claim payments? ☐ **Yes** ☐ **No**

May we speak with your other dental/medical providers regarding your dental treatment? ☐ **Yes** ☐ **No**

Please list the name of the dentist/physician: ____

Please list below any individuals we are allowed to release information to:

____ ____________________________ ____________________
Name **Phone #** **Date of Birth**

Relationship: ☐ Spouse ☐ Partner ☐ Parent ☐ Guardian ☐ Dependent ☐ Other ____________________
Information that we may release: ☐ All Information ☐ Financial Only ☐ Other ____________________

____ ____________________________ ____________________
Name **Phone #** **Date of Birth**

Relationship: ☐ Spouse ☐ Partner ☐ Parent ☐ Guardian ☐ Dependent ☐ Other ____________________
Information that we may release: ☐ All Information ☐ Financial Only ☐ Other ____________________

____ ____________________________ ____________________
Name **Phone #** **Date of Birth**

Relationship: ☐ Spouse ☐ Partner ☐ Parent ☐ Guardian ☐ Dependent ☐ Other ______________________
Information that we may release: ☐ All Information ☐ Financial Only ☐ Other ______________________

I understand that the above information will remain in force until changed by me in writing.

Patient Name: ____ Date of Birth: ___________________

Patient Signature: ____________________________________ Date: ___________________

Parent/Guardian: _____________________________________ Date: ___________________