# HIPAA RELEASE FORM

## *LAKE COUNTRY DENTAL & ASSOCIATES*

I,________________________________________, authorize the release of information of
(PRINT PATIENT / GUARDIAN NAME)

________________________________________, including the diagnosis, records, examination and
(PATIENT NAME)
treatment rendered to above patient, ledger and billing, and claims information.

This information may be released to (check one):

[ ] Spouse____________________________________________

[ ] Child(ren)__________________________________________

[ ] Other_____________________________________________

[ ] Information is not to be released to anyone. (Initial Here)_________

In further consideration for this, Lake Country Dental agrees to the same stipulations. This ***Release of Information*** will remain in effect until terminated by me in writing.

***Messages and communication from our office***

If we are unable to speak directly to you concerning matters pertaining to your care, please check one of the following preferences:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] other________________________________________________________

The best phone number to reach me at is:____________________________

Signed: _______________________________________ Date: ______/______/______

Witness:_______________________________________ Date: _____/______/_______