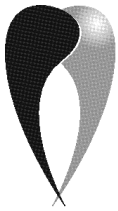

NORTH CAROLINA
ENDODONTICS

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Medical Information Release Form
HIPAA Release Form

Name: _____ Date of Birth: _____/_____/_____

We are unable to discuss your treatment with anyone unless you give us written permission.

[ ] I authorize the release of information including the diagnosis, records, images, examination rendered to me, and claims information. This information may be released to:

Please note: Certain treatments may require the patient be sedated. You will need to have a driver for such treatment. Your driver must be listed on this medical information release form prior to treatment.

[ ] My general and/or referring dentist Names: _____

[ ] Spouse Name: _____

[ ] Child(ren) Name(s): _____

[ ] Parent Name: _____

[ ] Other Name: _____

[ ] 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 [ ] work [ ] cell Number _____

If unable to reach me:

[ ] You may leave a detailed message
[ ] Please leave a message asking me to return your call
[ ] Other _____

The best time to reach me is (day) _____ between (time) _____.

I have received a copy of this office's Notice of Privacy Practices.

Signed: _____ Date: _____/_____/_____