RELEASE OF MEDICAL INFORMATION

PLEASE PRINT YOUR NAME: ____

BY SIGNING BELOW, I AUTHORIZE **Hardin Valley Family Dentistry** TO RELEASE MY MEDICAL AND BILLING INFORMATION TO:

RELATIONSHIP			NAME OF DESIGNATED PERSON
SPOUSE	YES	NO	______________________________
CHILDREN	YES	NO	______________________________
IN-LAWS	YES	NO	______________________________
CAREGIVERS	YES	NO	______________________________
PARENTS	YES	NO	______________________________

OTHERS ______________________________

PATIENT SIGNATURE ________________________________ DATE ___________________

PARENT SIGNATURE ________________________________ DATE ___________________

We ask that if you have any change in this request, that you please inform the receptionist.

Hardin Valley Family Dentistry MAY LEAVE APPOINTMENT INFORMATION ON MY VOICEMAIL:

HOME	YES	NO
WORK	YES	NO
RELATIVE	YES	NO

PATIENT SIGNATURE ____

I AUTHORIZE THE FOLLOWING TO PICK UP PRESCRIPTIONS, X-RAYS, ETC.

RELATIONSHIP			
SPOUSE	YES	NO	______________________________
RELATIVE	YES	NO	______________________________
CAREGIVER	YES	NO	______________________________

PATIENT SIGNATURE ________________________________ DATE ___________________

I UNDERSTAND THAT (PRACTICE NAME) WILL ASK FOR IDENTIFICATION OF THE PERSON PICKING UP PATIENT MEDICAL INFORMATION OR PRODUCTS.