I'On Family Dentistry

Request to Release Protected Health Information

Before I'On Family Dentistry can release your Protected Health Information to anyone, we must have your written authorization. Please fill out the information below.

Name(s) of person to whom information can be released:

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used, and disclosed as permitted 'Under the federal and state law, and outlining my rights regarding my health information.

Signature:_____Date:_____

Signature & Relationship:_____

(IF NOT SIGNED BY PATIENT)