fentonfamilydentistry
552 Old Smizer Mill Road
Fenton, Mo. 63026
Ph. (636) 326-7633
Fax (636) 600-1229
www.fenton-familydentistry.com

HIPAA Release

I, _____, authorize the release of **ALL** my HIPAA
Patient Name

protected information to _____.
Spouse/Family Member Name

I understand that this includes financial, scheduling, and medical information.

I understand that I may alter this declaration by submitting a written request.

I also authorize the listed person(s) above to make scheduling, treatment, and financial arrangements on my behalf.

☐ I authorize Fenton Family Dentistry to leave a message regarding any of my financial, scheduling, and medical information.
Ph: (___) ____-_____

☐ I authorize Fenton Family Dentistry to email any of my financial, scheduling, and medical information.
Email: _____

☐ I do not wish to share any of my HIPAA protected information to anyone.

I understand that I will still be financially responsible for any treatment performed, or products supplied to me.

_____ _____
Signature Date