

Medical Information Release Form (HIPAA Release Form)

Name: _____

Date of Birth: ____/____/____

Release of Information

I hereby authorize Martin N. Gorman, DDS and affiliates, employees, or agents to release any personal health information (e.g., information relating to the diagnosis, records, treatment, claims payment, and health care services) provided or to be provided to me to:

Parent/Spouse/Relative _____

Referring Provider _____

Primary Care Doctor _____

Others Consultants _____

I do not authorize Martin N. Gorman, DDS or affiliated to release any medical information.

**This Release of Information will remain in effect until terminated by me in writing.*

Messages

Please call my home my work my cell Number: _____

If unable to reach me:

you may leave a detailed message

please leave a message asking me to return your call

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

Signed: _____ Date: ____/____/____

Witness: _____ Date: ____/____/____