AUTHORIZATION TO RECEIVE/RELEASE HEALTH INFORMATION

Due to the **HIPPA Compliance Privacy Laws of the Federal Government,** it is mandatory that we ask you to review and answer the following questions listed below.

Name: _____

May we leave messages/detailed medical information on voice-mail at either of these phone numbers?

____ Yes ____ No Home Phone: _____

____ Yes ____ No Cell Phone: _____

May we contact you at your place of employment? ____ Yes ____ No

If so, may we leave a message? ____ Yes ____ No

Work Phone: _____ Ext: _____

Please list anyone authorized to receive and/or discuss your personal information (general information, treatment, or account information)

Name: _____

Relationship: _____

I hereby authorize John I. Park, D.M.D., P.A. to obtain or release all pertinent information regarding my dental care, as needed, to assist in my ongoing treatment to or from other health care providers, laboratories, or other institutions.

This authorization remains in effect until revoked.

I have reviewed the Notice of HIPPA Privacy Policy. A copy will be provided to me upon request.

Patient Signature: _____ Date: _____