Medical Information Release Form

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

(From Instructions: Place initials in appropriate boxes [ ] , Sign form on bottom)

Release of Information

[ ] I authorize the release of information including the diagnosis, records, billing, examination rendered to me and claims information. This information may be released to:

[ ] Spouse____________________________________
[ ] Child(ren)__________________________________
[ ] Other_____________________________________

[ ] Information is not to be released to anyone.

Messages

Messages may be left by employees of Wexford Family Dentistry or an Automated Messaging Service

Please call [ ] my home [ ] my work [ ] my cell Number:________________

If unable to reach me:

[ ] you may leave a detailed message
[ ] you may text a detailed message
[ ] please leave a message asking me to return your call
[ ] ______________________________________

The best time to reach me is (day)_________________ between (time)________

Emails

[ ] I Authorize **Wexford Family Dentistry** to email pictures of the patient(s) and x-rays, appointment reminders, school excuses, and statements and receipts.

Pictures

[ ] I Authorize **Wexford Family Dentistry** to place pictures of the patient(s) in the office.
[ ] I Authorize **Wexford Family Dentistry** to place pictures of the patient(s) on office related social media.

Authorization:

Name: ________________________________ Date of Birth: ____/____/____

Signature: ____________________________ Date: __________________

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