Management of Private Medical Information

Permit for Release of Medical Information

Patient Name:_____ DOB:_____.

I do _____ I do not_____ authorize messages containing medical information to be left on my answering machine at phone # _____.

You may discuss patients' medical information with the following people:

Name_____ Phone _____

Name_____ Phone _____

Name_____ Phone _____

Name_____ Phone _____

You may_____ You may not_____ call me_____ leave messages_____ at my workplace.

Work Phone # (_____)_____-_____

Other requests: _____

_____.

I have been given or offered the HIPPA Patient Privacy notice for Custom Dental of Harrisonville

Print Name:_____

Signature: _____ Date:_____

I hereby give my consent for Custom Dental take my photograph. By signing this form, I give Custom Dental permission to use the material gathered to train other doctors within the dental group or include the information and photographs in public marketing pieces only **after verbal consent is given.

_____

Signature