Town Center Dental Office
4434 University Pkwy., Ste. G
San Bernardino, CA 92407
909-887-1533

# Dental Information Release Form
# (HIPAA Release Form)

Patient Name:_____ Date of Birth: ___/___/_____

## ***Release of Information***

[ ] I authorize Town Center Dental Office to release my information/records including the examination rendered, diagnosis, treatment purposed/performed, and claim information. This information maybe released to:

[ ] Spouse: _____ ___/___/_____
Name Date of Birth

[ ] Child(ren): _____ ___/___/_____
Name Date of Birth

_____ ___/___/_____
Name Date of Birth

[ ] Other: _____ ___/___/_____
Name Date of Birth

[ ] INFORMATION IS NOT TO BE RELEASED

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

Signed: _____ ___/___/____
Date

Witness: _____ ___/___/_____
Date

_____
Printed name of witness