GROOVER FAMILY DENTISTRY

HIPPA AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

By signing this authorization, you agree to release your protected health information as described in this authorization. This authorization is intended to comply with the requirements of the HIPPA PRIVACY RULE. If you have questions about this authorization, please contact the privacy official for the dental practice. If you agree with this authorization, please complete it, sign and date it at the end.

YOUR CONTACT INFORMATION (please complete)

Patient First Name____________________________ Patient Last Name___________________________________

Patient address____

Patient date of birth____

I am requesting that this dental practice receive my dental records, radiographs, and all pertaining notes to be released to GROOVER FAMILY DENTISTRY AT GROOVERFAMILYDENTISTRY@GMAIL.COM.

Our mailing address if needed is 711 E. 70th Street, Suite B, Savannah, GA 31405. Our office phone number is (912) 354-9541.

I give my permission to release my information from

PREVIOUS OFFICE NAME____

PREVIOUS OFFICE PHONE NUMBER_______________________________________

By signing this document with my signature, I certify that I have read and understand this authorization. I am signing it voluntarily. I authorize the disclosure of my protected health information as described in this authorization and agree to release my records.

PATIENTS SIGNATURE____ DATE______________________

OR

SIGNATURE OF PERSONAL REPRESENTATIVE_______________________________________

PLEASE LIST PARENT, GUARDIAN, POWER OF ATTORNEY, OTHER_________________________________