



KEVIN PRUSH, D.D.S.

**DIVERSIFIED
DENTAL**

Family Dentistry • Cosmetic Dentistry

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Medical Information Release Form

(HIPAA Release Form)

Name: _____

Date of Birth: ____/____/____

Release of Information

I authorize the release of information including the diagnosis, records; 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.

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

Messages

Please call or contact me by: my home my work my cell

If unable to reach me:

you may leave a detailed message

please leave a message asking me to return your call

The best time to reach me is (day)_____ between (time)_____

Signed: _____ Date: ____/____/____

Witness: _____ Date: ____/____/____

The signed acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated documentshall be as effective as the original. This Document is also posted in our facility at our check-in counter. *You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.