KEVIN PRUSH, D.D.S.
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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_____ **(PLEASE LIST THEIR FULL NAME)**

[ ] Child(ren)_____ **(PLEASE LIST THEIR FULL NAME)**

[ ]Other_____ **(PLEASE LIST THEIR FULL NAME)**

[ ] *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

Signed: _____ Date: ____/____/_____

Witness:_____ Date: ___/____/_____

The signature acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall 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 to sign we may not be allowed to process your insurance claims.