ELROD & DUNHAM DENTISTRY
"Where smiles come together"

Elrod and Dunham Dentistry - Bell Creek
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www.elroddunhamdentistry.net/

HIPAA – RELEASE OF INFORMATION AUTHORIZATION FORM
| DOB:

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In compliance with federal and state law, the release of information for any person 18 years or older (including the information regarding a spouse or adult child), **must first be authorized**. Authorization includes the signature of the individual authorizing the release of their information. Information **will not be available** to anyone other than the covered patient (i.e. a member, a spouse, or any dependent age 18 or older) without first having this Release of Information Authorization on file. For example, if a subscriber calls about the status for a claim on a 19-year old dependent, that information will not be given to the subscriber without the written consent of the dependent. The same situation holds true for spouse-to-spouse information. However, parents do have a right to information on children under the age of 18 without the child's consent.

I want to provide the authorization	

Information Regarding Person Authorizing Releasing His/Her Information

Name of person authorizing release	
Date of Birth person authorizing release	
Personal Information to be released	
The above information may be released and/or received by	

The following is an authorization allowing Elrod and Dunham Dentistry - Bell Creek to release information to whomever you designate. Elrod and Dunham Dentistry - Bell Creek is authorized to make the disclosure of my benefits information, claim(s) status, claim(s) history, general claim information, dentist information, lab cases, and enrollment information, unless otherwise specified to the following individual(s) or organization(s):

Name of person/organization that the office may release my information to	
Relation of person/organization that the office may release information to	
Phone number of person/organization that the office may release information to	
I want to add a second person/organization	
Name of person/organization that the office may release my information to	
Relation of person/organization that the office may release information to	
Phone number of person/organization that the office may release information to	
I want to add a third person/organization	
Name of person/organization that the office may release my information to	
Relation of person/organization that the office may release information to	
Phone number of person/organization that the office may release information to	
I want this consent to	

AUTHORIZATION CONSENT

I understand that consent may be revoked by me at any time in writing. I understand why I have been asked to disclose this information and am aware that my patient rights are identified in the practice's Notice of Privacy Practices.

Patient's signature: Date: