LAKEWOOD
DENTAL ARTS
DENTISTRY · ORTHODONTICS

Personal Health Information Release Form

HIPAA Release Form

Patient 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 _____
- ☐ Non-custodial Parent _____
- ☐ Grandparent(s) _____
- ☐ Adult Child(ren) _____
- ☐ Other (specify name/relation) _____

☐ Information is not to be released to anyone.

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

Patient/Parent/Guardian Signature