HIPAA Release Authorization Form

Romine Family Dental

In compliance with the Health Insurance Portability and Accountability Act (HIPAA), we are unable to discuss your treatment or account information with anyone unless you provide written authorization.

Patient Name: _____

Date of Birth (DOB): ____ /____ / ___

Authorization to Release Information

Please select **ONE** of the following options:

☐ **I do NOT authorize** Romine Family Dental to release any information regarding my treatment, diagnosis, or account to anyone.

☐ **I DO authorize** Romine Family Dental to release information, including diagnosis, records, images, examination findings, and claims information to the following individuals:

(Check all that apply and write the name where applicable):
☐ **Spouse: _____**
☐ **Child(ren): _____**
☐ **Parent(s): _____**
☐ **Other: _____**

This authorization will remain in effect until revoked **in writing** by the patient.

Phone Contact and Message Authorization

I give permission to be contacted by Romine Family Dental at the following (check all that apply):
☐ **Home Phone**
☐ **Work Phone**
☐ **Cell Phone**

When leaving a voicemail, you may:
☐ Leave a **detailed message**
☐ Leave a **brief message** requesting a return call only

Signature and Acknowledgment

Patient Signature: _____

Printed Name: _____

Date: _____ / _____ / _____