MOUNTAIN SPRINGS
DENTAL

HIPAA PRIVACY AUTHORIZATION FORM

I, _____, authorize Mountain Springs Dental and applicable staff to release health/dental information to:

Name of person (spouse or family member) to receive information: _____

Street Address: _____

City, State, Zip Code: _____

[ ] I DO NOT AUTHORIZE THE RELEASE OF MY INFORMATION.

The purpose of this release is for:
[ ] Continuity of care
[ ] Billing and payments
[ ] At the request of the patient/ patient representative
[ ] Other (state reason) _____

Please specify the health/dental information you authorize to be release:
_____
_____
_____
_____

Expiration of Authorization:
I understand that I have the right to revoke this authorization in writing, at any time.

Printed Name: _____ Date of Birth: _____

Signature: _____ Date Signed: _____

Witness: _____