Medical Information Release

I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to: **(EX: Spouse, children, etc.)**

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Or ☐ Information is not to be released to anyone.

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

X_____

Patient Name (please print)

X_____ _____

Patient(guardian) Signature **Date**

Vistoso Dental Partners

Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

I acknowledge that I have received a copy of this Dental Practice's HIPAA Notice of Privacy Practices. **Please Note: It is your right to refuse to sign this Acknowledgement.** **(if you would like to see this please ask)**

X_____

Patient Name (please print)

X_____ _____

Patient Signature **Date**

*Authority of Personal Representative to sign for Patient (check one) **if applicable:**

☐ Parent ☐ Guardian ☐ Power of Attorney ☐ Other: _____

_____ _____

Printed name of Personal Representative **Signature of Personal Representative**