IMPERIAL
FAMILY
DENTAL
CENTER

HIPAA RELEASE FORM

This form is for use when such authorization is required and compiles with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

For us to stay within guidelines, please list below anyone that you authorize us to disclose information to regarding your Protected Health Information. It is not mandatory that you list anyone. (**You do not need to list any of your doctors**).

Name **Relationship**

1._____ **_____**

2._____ **_____**

3._____ **_____**

Do we have your permission to leave information on your answering machine/voicemail/text message if we are unable to reach you? _____ Yes _____ No

Cell phone:_____

Home phone:_____

_____ **_____**

Patient's Name (Please Print) **Date of Birth**

_____ **_____**

Patient or Parent/Guardian Signature **Today's Date**