PUCKER UP
Dental Spa

HIPAA RELEASE OF INFORMATION AUTHORIZATION

Consent for access to Protected Health Care Information:

I give consent to the staff at Pucker Up Dental Spa to communicate with the person(s) listed below regarding my medical treatment. I consent to the use of my protected Health Care Information when communicating in person, by telephone, mail, e-mail, fax, or other means. I may withdraw this consent at any time by notifying Pucker Up Dental Spa in writing. Any communication prior to such notice will be considered to have been authorized by me.

Patient Signature:_____ Date:_____

PLEASE LIST NAMES OF PERSONS OR FAMILY

YOU AUTHORIZE TO RECEIVE INFORMATION ABOUT YOU

Name_____Relationship to patient_____

Name_____Relationship to patient_____

Name_____Relationship to patient_____

Name_____Relationship to patient_____