

**RK Dentistry**  
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Medical Information Release Form  
(HIPAA Release Form)

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Release of Information**

I authorize the release of Dental information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

Spouse \_\_\_\_\_

Child(ren) \_\_\_\_\_

Other \_\_\_\_\_

Information is not to be released to anyone.

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

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

Date: \_\_\_\_\_

