



HIPAA Information Release Form

I hereby give Denali Family Dentistry permission to release the following personal health information (PHI) to the below entity(s). I understand this allows Denali Family Dentistry to disclose information from the following selected options: (Please mark with an X)

_____ Health _____ Treatment _____ Future/Past Appointments

_____ Billing _____ Scheduling appointments

To the following person:

Name: _____

Relationship: _____

I understand that upon signing this document, I am giving permission to disclose PHI to the selected entity(s). I understand I may withdraw this permission at any time in writing.

Signature of Patient _____

Printed Name of Patient _____

Date _____

Date of withdrawal _____ Signature _____