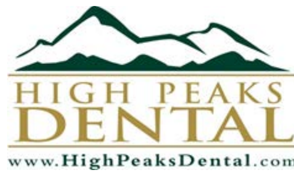

HIPAA AUTHORIZATION FORM

This form describes how health information about you may be used and disclosed and describes who you may permit access to such information. Please fill out this authorization form accurately and completely.

Name: ______________________________________

Phone _____________________ Cell_________________ _____Work ___________________________

I, __________________________________, hereby authorize High Peaks Dental to release any and all medical information and results that pertain to me, to the following individual(s):

Name ____________________Phone _____________________Relationship to patient________________

Name ____________________Phone _____________________Relationship to patient________________

Name ____________________Phone _____________________Relationship to patient________________

Name ____________________Phone _____________________Relationship to patient________________

I authorize High Peaks Dental to contact the individual(s) listed above to convey any pertinent information about myself, in the event that I am unable to be contacted by the staff.
I understand that I may cancel or edit this authorization by notifying High Peaks Dental in writing of my revocation of authorization of the individual(s) to whom my information is to be released.

__________________________________ __________________________________
Signature of Patient Date

__________________________________ __________________________________
Signature of Guardian (if applicable) Date

__________________________________ __________________________________
Signature of Witness Date