ROCKCASTLE
FAMILY DENTAL CENTER

CONSENT FOR RELEASE OF INFORMATION

I authorize Rockcastle Family Dental Center to disclose my information to a third-party recipient, such as a spouse, parent, significant other etc., as I designate below. If the form is not completed in its entirety, the requested information will not be disclosed to the recipient identified. This authorization is in compliance with Federal privacy regulations including the U. S. Department of Health and Human Services Privacy Rule.

I authorize:

Name:	Phone Number:	Relationship to Patient:
____________________	____________________	________________
____________________	____________________	________________
____________________	____________________	________________

To receive information on the following: **Please check all that apply**

◯ Information related to my dental/medical treatment

◯ Information related to payment of my dental/medical treatment and/or claims

◯ I do not give authorization for my information to be disclosed.

I authorize Rockcastle Family Dental Center to leave information about my appointments, treatment and finances on my voicemail/email:

◯ Yes, I consent for information to be disclosed via voicemail/email.

◯ No, I do not consent for information to be disclosed via voicemail/email.

____ ________________________

Patient's Name Patient's Date of Birth

____ ________________________

(Signature of person giving consent) Date