

# PENINSULA FAMILY DENTISTRY

606 DENBIGH BLVD., STE 300 NEWPORT NEWS, VA 23608

## HIPAA RELEASE FORM

Patient name: \_\_\_\_\_

Privacy regulations require us to have a release signed by our patients so we may speak with family members, friends and other relations regarding your medical treatment and patient financial information. Each person you wish to be considered a contact must be listed individually by name (including a SPOUSE or SIGNIFICANT OTHER).

Please print name, relationship and telephone number for each person to whom you are authorizing release of your private health information and account balances.

_____ Name	_____ Relationship	_____ Phone #
_____ Name	_____ Relationship	_____ Phone #
_____ Name	_____ Relationship	_____ Phone #
_____ Name	_____ Relationship	_____ Phone #

This authorization will expire on: \_\_\_/\_\_\_/\_\_\_ (fill in date if less than 1 year) or one year after being signed.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date