FREDERICKSBURG DENTAL ASSOCIATES
DRS. GALATRO, WADIAK AND ASSOCIATES

# Authorization to Release Patient Information (HIPAA)

Today's Date: _____

Patient's Name: _____

I, _____ hereby authorize Fredericksburg Dental Associates and/or their representatives to release any and all information pertaining to my dental healthcare including: results, procedures, billing, and/or accounting information to the following person(s) or agencies:

Myself only, please initial: _____

Spouse, full name: _____

Parent(s), full name(s): _____

Other, specify full name(s) & relationship: _____

I understand that this office will release any information to those persons who I have determined may receive this information without separate consent. I also understand that this relates to all medical and billing/account information.

I reserve the right to:

- Revoke this authorization in writing by submitting it to the attention of your Privacy Officer.
- Inspect or copy the protected health information to be used or disclosed.
- Refuse to sign this authorization knowing that you will not condition treatment or payment on my providing this authorization (except for research related treatment).

Patient signature (or responsible party if minor): _____

Relationship (if other than patient): _____

Date Signed: _____