GibbsDentistry

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HIPAA FORM

Patient full name *(please print):* _____

Patient address: _____

Patient phone: _____

I authorize **Gibbs Dentistry** to release my patient information, other than my insurance company, to the following person(s):

Name: _____

Relationship: _____

Address: _____

Phone: _____

Name: _____

Relationship: _____

Address: _____

Phone: _____

I understand that I have the right to revoke this authorization at any time. My revocation must be in writing and provided to **Gibbs Dentistry**.

I am signing this form voluntarily and I understand that failure to sign this authorization form will result in the non-release of my protected health information.

Patient signature: _____ Date: _____

Parent/Guardian signature: _____ Date: _____