**The Smile Zone**

**576 Sand Creek Road Albany New York 12205**

**HIPAA Release Form**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

We are unable to discuss your treatment with anyone unless you give us written permission.

**[ ]** I authorize the release of information including the diagnosis, records, images, examination rendered to me, and claims information. This information may be released to:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Please note**: If you have elected to be sedated, you will need to have a driver for your appointment. Your driver must be listed on this medical information release form prior to treatment.

**[ ]** Information is not to be released to anyone.

This release of information will remain in effect until terminated by me in writing.

**Messages**

Please call my [ ] home [ ] work [ ] cell Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If unable to reach me:

[ ] You may leave a detailed message on voicemail

[ ] You may leave a message with a person

[ ] Please leave a message asking me to return your call

[ ] Other (text,email)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The best time to reach me is (day) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ between (time) \_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**I have received a copy of this office’s Notice of Privacy Practices.**

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

\*\*You can refuse to sign this form. If so, no claims will be filed with your insurance carrier and you must pay for your treatment in cash only.