Bryant
FAMILY DENTISTRY

HIPAA Release Authorization Form:

I,_____, hereby authorize Bryant Family Dentistry to release my dental records and/or discuss my dental treatment with the following individual(s).

Name:_____ Phone: _____ Relationship to Patient: _____

Name:_____ Phone: _____ Relationship to Patient: _____

Name:_____ Phone: _____ Relationship to Patient: _____

Name:_____ Phone: _____ Relationship to Patient: _____

I authorize Bryant Family Dentistry to release my dental records and/or discuss my treatment with the above individual(s).

I understand that I may cancel or edit this authorization at any time by contacting Bryant Family Dentistry in writing.

_____ _____

Signature of Patient Date

_____ _____

Signature of Parent or Guardian (if applicable) Date