Meadow Place Dental
200 North Main Street, Suite 1104
East Longmeadow, MA 01028

AUTHORIZATION TO RELEASE INFORMATION

The HIPAA (Health Insurance Portability and Accountability Act) Privacy Act does not allow for unauthorized disclosure to a patient's family member, friends, or advisors. If the patient would like their protected health information released to someone other than himself or herself they must complete the bottom half of this form. A patient cannot specify which information they would like released to this third party. By completing this form, all protected health information may be released to the third party upon request until this agreement is terminated in writing.

I, _____, give Meadow Place Dental
(Print Name)

permission to discuss with:

_____ _____
(Print Name) (Relationship to Patient)

_____ _____
(Print Name) (Relationship to Patient)

_____ _____
(Print Name) (Relationship to Patient)

_____ _____
(Print Name) (Relationship to Patient)

Permission to leave a message on

_____ home/cell telephone answering machine # _____

_____ work voice mail # _____

any information pertaining to my healthcare.

Signature: _____

Date: _____

Print Full Name: _____

Witness :_____(Sign and Print Full Name)