

STEFANO DENTAL, INC
1617 W. Bogart RD
Sandusky, Ohio 44870
419-626-2205

Release Form for Patient Information

Patient Name: _____ Patient's Date of Birth: _____

Stefano Dental has my permission to let a caller or visitor know that I am a patient here and/or that I am here: Yes _____ No _____

I hereby authorize Stefano Dental to release my patient information. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA Privacy regulations.

The following person(s) may receive my patient information:

I understand that I may revoke this authorization at any time, and that my revocation is not effective unless it is in writing and received by the dental practice's Privacy Official at 1617 W. Bogart Rd, Sandusky, Ohio 44870. If I revoke this authorization, my revocation will not affect any actions taken by the dental practice before receiving my written revocation.

I understand that I may refuse to sign this authorization, and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

Consent Related to the Privacy Notice:

I have had a chance to review the Practice Privacy Notice as part of this process. I understand that the terms of the privacy notice may change and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but the practice is not required to agree to my restrictions. If it does agree to my restrictions on PHI use, it is bound by that.

Signature of Patient or Patient's Personal Representative:

_____ Date _____

If Personal Representative:

Print Name: _____

Signature: _____ Relationship to Patient: _____

For office use only: Copy of signed authorization provided to the individual:

Date: _____

Initials: _____