BRUCE A. WEITZ D.D.S. INC.

AUTHORIZATION TO RECEIVE/RELEASE HEALTH INFORMATION

Due to the HIPAA Compliance Privacy Laws of the Federal Government, it is mandatory that we ask you to review and answer the following questions listed below.

Name _____

May we leave messages and or detailed medical information on voicemail at either of these phone numbers?

_____ Yes _____ No Home Phone: _____

_____ Yes _____ No Cell Phone: _____

May we contact you at your place of employment? _____ Yes _____ No

If so, may we leave a message? _____ Yes _____ No

If yes, Work Phone: _____ Extension: _____

Do you have any particular person or family members that you authorize to receive and discuss information regarding your personal health information (general information, dental needs, and billing)?

_____ Yes _____ No If yes, please provide:

Name: _____ Relationship: _____

Phone number: _____ Alternate number: _____

Is this person your Power of Attorney for medical purposes? _____ Yes _____ No

I hereby authorize BRUCE A. WEITZ DDS INC to obtain or release any and all pertinent information regarding my dental care, as needed, to assist in my ongoing treatment to or from other dental care specialists, health care providers, laboratories, or other institutions. **This authorization remains in effect until revoked**.

I have reviewed BRUCE A WEITZ DDS INC Notice of HIPPAA Privacy Policy. A copy of this policy will be provided to me upon request.

Patient signature: _____ Date: _____

Guardian / Representative Signature: _____
(If patient cannot sign or is a minor)

Witnessed By: _____