



DEXTER DENTAL STUDIO

Healthy Mouth. Healthy Body. Healthy Mind.

7300 Dexter Ann Arbor Rd.
Suite 300
Dexter, MI 48130

Medical Information Release **HIPAA Release Form**

Name: _____

Date of Birth: ___/___/_____

Release of Information

() I authorize the release of information including the diagnosis, records, examination rendered to me, and claims information. This information may be released to:

() Spouse(full name): _____

() Child(full name): _____

() Other(full name): _____

() Information is not to be released to anyone.

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

Patient's Signature