SPRING CREEK
DENTAL

422 2nd Street
Hudson, WI 54016

Authorization to Release & Discuss Dental Information

The HIPAA privacy law requires that we are only authorized to communicate with patients themselves, guardians, insurance providers and primary care physicians, unless we have authorization in writing by the patient to communicate with others on their behalf. Please provide all family members or friends you want us to be able to speak with. **Spouses are not automatically included**; their names must be explicitly stated below. You may opt out by signing under the "Do not release my information to anyone" portion of this form.

I give the following named person authorization to take messages or speak with representative of Spring Creek Dental, on my behalf regarding (please check all items authorized).

Patient Name: _____

Name of authorized person(s): _____

Relationship _____ Phone number _____

____ Appointments ____ Financial _____ Dental Treatment ____ Insurance _____ Other

Patient Signature: _____ Date _____

Do not release my information to anyone

I understand that my express consent is required to release any health care information. With my signature below, I acknowledge and understand that this information will be kept in my dental record and the above parameters will remain in effect until revoked by me in writing.
It is my responsibility to notify my healthcare provider(s) should I wish to change one or more contacts listed above.

Patient's Name: _____Date of Birth _____

Patient Signature: _____ Date _____