KINGSEED
FAMILY DENTAL

3960 Clarks Creek Road
Plainfield, IN 46168
(317) 268-4953 ● (317) 268-4967 (Fax)

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient Name:_____
Patient Address: _____
Patient Phone: _____

HEALTH INFORMATION PRIVACY POLICY & PROCEDURES

I authorize the release of information including the diagnoses, records, examination rendered to me, and claims information. This information may be released to (Check All That Apply):

- Spouse_____
- Children_____
- Other_____
- Information about my treatment/insurance is okay to be discussed on a voicemail.
- Information is not to be released to anyone.

I understand that Kingseed Family Dental works in connection with other Health Care Professionals. If I am referred to a specialty office including but not limited to Oral Surgery, Endodontics, Prosthodontics, Periodontics, and Orthodontics, I authorize the release of information of (Check All That Apply):

- XRAYS
- CHARTS
- INSURANCE INFORMATION
- Information is not to be released to anyone.

YOUR REQUIRED SIGNATURE HERE IS ACKNOWLEDGMENT OF HIPPA PRIVACY ACT

Date _____ **Patient/Guardian X_____**