Dental Practice of Mianecki & Carlino D.D.S., P.C.

Medical Information Release Form

HIPPA RELEASE FORM

NAME: _____

Date of Birth: _____/_____/_____

Release Information

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. The information may be release to:

_____ Spouse _____

_____ Child _____

_____ Other _____

_____ Information is not to be released to anyone

Signature _____

Date _____

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