

Cutbirth & Sanderson, D.D.S., L.L.P.

827 S. Magnolia Blvd., Suite 1

Magnolia, TX 77355

PH: 281-356-3721 FAX: 281-356-3778

*Dental Information Release Form
(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 _____

Child(ren) _____

Other _____

Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call my home my work my cell Number: _____

If unable to reach me:

you may leave a detailed message

please leave a message asking me to return your call

The best time to reach me is (day) _____ between (time) _____

Signed: _____ Date: ____/____/____

Witness: _____ Date: ____/____/____