SAN ANTONIO
PERIODONTICS & IMPLANTS
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MEDICAL INFORMATION RELEASE FORM (HIPAA RELEASE)

Name: _____ Date of Birth: _____

☐ I authorize the release of my Protected Health Information (PHI) to the individuals listed below:

- ☐ Spouse _____
- ☐ Child(ren) _____
- ☐ Other _____

☐ Information is not to be released to anyone.

This Medical Information Release (HIPAA Release) will remain in effect until terminated by me in writing.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____