David T. Rothan, DDS, General Dentist • Michael J. Rothan, DDS, General Dentist

HIPAA Privacy Authorization Form

Patient Name: ____________________________________
(Please Print)

Privacy regulations require us to have releases signed by our patients for us to speak with family members, friends, and other relations regarding dental treatment. Each person must be listed individually and by name.

Please check each box you would give permission for the following people to receive and print name, relationship, and telephone number for each person to whom you are authorizing release of your private dental care information.

- ☐ Dental Records
- ☐ Treatment Records
- ☐ Diagnostic Records
- ☐ Financial Records
- ☐ Others: ____
____
____

☐ I *do not* give permission to release my information

Name	Relationship	Phone Number
____________________	____________________	______________
Name	Relationship	Phone Number
____________________	____________________	______________
Name	Relationship	Phone Number
____________________	____________________	______________
Name	Relationship	Phone Number

Patient Signature: ______________________________________ **Date:** ______________

Witness Signature: ______________________________________ **Date:** ______________