HIPAA RELEASE FORM

Dr. Cheryl Alper, DMD

I, _____, authorize the release of information of

(PRINT PATIENT/GUARDIAN NAME)

_____, including the diagnosis, records, examination and

(PATIENT NAME)

treatment rendered to above patient, ledger and billing, and claims information.

This information may be released to:

[ ] Spouse_____

[ ] Children_____

[ ] Other _____

[ ] Information is not to be released to anyone. (Initial Here)_____

In further consideration for this, Dr. Cheryl Alper, DMD agrees to the same stipulations. This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages and communication from our office

If we are unable to speak directly to you concerning matters pertaining to your care, please check one of the following preferences:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] other_____

The best phone number to directly reach me at is: _____

Sign:_____Date:_____/_____/_____

Witness:_____Date:_____/_____/_____