Laura Philipps, D.M.D

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Social Security #: _____

I authorize **Laura Philipps, D.M.D.** to release any health/dental care records that are relevant for my patient care or insurance benefits to any medical, dental or insurance provider who may request it.

☐ Health & Dental Care Information

☐ Other: _____

Definition: HIPAA Privacy Rule requiring consent from dependent of age 17 yrs or older in releading health/dental information to parent or guardian.

I understand that I have the right to revoke this authorization, and that I must do so in writing. I understand that any such revocation will not affect any actions taken by the office of Laura Philipps, D.M.D. in reliance on this authorization before its revocation.

This authorization expires at which time the above patient is solely responsible for his/her account and not dependent on parents.

Patient Signature: _____ Date Signed: _____

Guardian Signature: _____ Date Signed: _____