HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

CONSENT FOR RELEASE OF DENTAL X-RAYS AND/OR DENTAL RECORDS

PATIENT GIVING CONSENT TO RELEASE DENTAL X-RAYS AND/OR DENTAL RECORDS **FROM:**

____

(DOCTOR'S OFFICE NAME)

____

(DOCTOR'S ADDRESS)

RELEASE TO:

Cynthia S. Becker D.D.S.   Cynthia A. Pistoia D.M.D.

(DOCTOR'S OFFICE NAME)

9905 Allisonville Road - Fishers, IN 46038

(DOCTOR'S ADDRESS)

PATIENT'S NAME: ____

ADDRESS: ____

TELEPHONE NUMBER: ____

SOCIAL SECURITY NUMBER: ____

PATIENT'S SIGNATURE: ______________________________**DATE:** ________________

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