

KC DENTAL

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HIPAA Release Form

Privacy regulations require us to have a release signed by our patients so we may speak with family members, friends and other relations regarding your dental/medical treatment and patient financial information. Each person you wish to be considered a contact must be listed individually by name.

Please print name, relationship and telephone number for each person to whom you are authorizing release of your private health care information and account balances.

_____ Name	_____ Relation	_____ Phone Number
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_____ Print Patient Name	_____ Date
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_____ Patient/Legal Guardian signature	_____ Date
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