Columbia Implants & Periodontics LLC
Practice Limited to Periodontics
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* You May Refuse to Sign This Acknowledgment*

I have read and understand this office's Notice of Privacy Practices (HIPAA) which is posted in the waiting room and/or available upon request.

Print Name:____

Date of Birth: _____/____/_____

Release of Information

[ ] I authorize the release of information including appointment information, diagnosis, records, examination rendered to me and claims information. This information may be released to:

[ ] Spouse__________________________________

[ ] Child(ren)________________________________

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[ ] General Dentist ______________________________

[ ] Other ______________________________

[ ] Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Signed: ________________________________ Date: ____/____/_____