Belmont Dental Associates
3210 E Market Street
York, PA 17402

# HIPAA Form

## Release of Information:

I,_____ authorize Belmont Dental Associates to use the following protected health information and/or disclose the following information including diagnostic records, treatment records, appointment information, and claims information. This information may be disclosed to:

_____Relationship to Patient _____Phone Number_____
_____Relationship to Patient _____Phone Number_____
_____Relationship to Patient _____Phone Number_____

You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment or payment, or your eligibility for benefits. This disclosure of information will remain in effect until terminated by the individual in writing by sending notification to Belmont Dental Associates.

## Communication:

Please call: Home: _____ Cell: _____ Work: _____
If unable to reach you may we:

- Leave a message on your cell or home phone? _____
- If preferred may we email you? If so please provide the best email address to reach you: _____
- Would you like to receive text messages via your cell phone number? _____

I acknowledge that I may request a copy of the office's Notice of Privacy Practices at any time, and I am responsible for providing the dental practice any updates to my email address or phone numbers. I can withdraw my consent at any time to receive the above communication by informing Belmont Dental Associates.

_____ _____

Patient Signature Date