Medical Information Release Form
(HIPAA Release Form)

Patient Name: _____

Date of Birth: _____/____/_____

Release of Information

I authorize the release of information to the following person(s) to include all aspects of my chart/account with Shane R. Claiborne, DDS, PLLC.

Name and Relation:

_____

_____

_____

[ ] Information is not to be released to anyone.

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

Signature of Patient or Guardian if minor: _____

Date of Signature: _____