CHESTERFIELD
FAMILY DENTISTRY
Dr Jonathan W. Silva 314-878-9808
www.ChesterfieldFamilyDentistry.com
13463 Olive Blvd, Chesterfield, MO 63017

HIPAA INFORMATION RELEASE AUTHORIZATION and ACKNOWLEDGEMENT

I, _____ authorize the release of ALL of my
(Patient Name)
HIPAA protected information to: _____ PH: (___)_____
(Spouse/Family Member Name) (Authorized Spouse/Family Member Phone)

- I understand that this includes financial, scheduling, and medical information.
- I understand that I may alter this declaration by submitting a written request.
- I also authorize the listed person(s) above to make scheduling, treatment, and financial arrangements on my behalf.

❑ I authorize Chesterfield Family Dentistry to leave a message regarding any of my financial, scheduling, and/or medical information. @

PATIENT PHONE NUMBER: ( ) ___ ❒Home ❒ Mobile ❒ Work

❑ I authorize Chesterfield Family Dentistry to email any of my financial, scheduling, and medical information. I understand my information will not be shared with any 3rd party providers.

PATIENT EMAIL:

I understand that I will still be financially responsible for any treatment performed, or products supplied to me.

Acknowledgement of Receipt of Notice of Privacy Practices

Your name and signature on this sheet indicate that you have been given the opportunity to review and request a copy of Chesterfield Family Dentistry's Notice of Privacy Practices (Notice) on the date indicated. If you have any questions regarding the information, please do not hesitate to contact a clinic representative or the CFD Patient Privacy Officer as indicated on your Notice.

_____ _____
Patient Signature Date

You have the right to review our privacy notice, to request restrictions and revoke consent, in writing, after you have reviewed our privacy notice.

OR

❑ I do not wish to share any of my HIPAA protected information to anyone at this time

** Please note - We must have this form on file before we can release any information to anyone other than the patient or legal guardian