Denver
ORAL & MAXILLOFACIAL
SURGERY

HIPAA Release Form

Name: _____ Date: _____

Release of Information

_____ I authorize the release of information including but not limited to diagnosis, treatment, and financial matters. This information may be released to or discussed with the following person(s):

Name: _____ Relation: _____ Phone: (_____) _____-_____

Name: _____ Relation: _____ Phone: (_____) _____-_____

Name: _____ Relation: _____ Phone: (_____) _____-_____

_____ I DO NOT authorize information to be released to anyone.

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

Messages

S. Matt Schacht, D.D.S., P.C. offers E-mail and Text Message notifications for Appointment Reminders and other patient care related information. This system will allow you to verify appointment at a time convenient to you, to request future appointments, and to keep you informed of office and patient care information. If you choose to opt-in to this system please provide us with your email address and text messaging number below. This information is only used for S. Matt Schacht, D.D.S., P.C. purposes and is governed by the same HIPAA protection as all other information. We will start utilizing this system once we have enough text/email addresses from our patients' parents/guardians.

Your Name _____

E-Mail _____

Mobile Number _____

I authorize S. Matt Schacht, D.D.S., P.C. to notify me of patient care related information using these different methods. (Please circle any that apply)

Text Messaging E-Mail Voicemail

Signature: _____ Date: _____