New Hampshire Center *for* Comprehensive Dentistry

RELEASE OF MEDICAL AND FINANCIAL INFORMATION

Name:______________________________________ Date of Birth:____________________

HIPPA privacy regulations require New Hampshire Center for Comprehensive Dentistry to have a release signed by our patients so we may speak with family members, friends and other relations regarding your medical treatment and financial information.

Please Print Name (first and last) and the relationship for each individual to whom you are authorizing release of the above information.

Name	Relationship

I understand I have the right to revoke this authorization in writing at any time and any information disclosed to the above individual (s) is no longer protected by federal or state law.

____ ____________________

Patient Signature Date