GRADY | KASTNER | GORNICK
ORTHODONTICS

Medical Information Release Form

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

Patient Name: _____ Date of Birth: _____/____/_____

Release of Information

I, _____, (relationship to patient**)** _____authorize the release of information including the diagnosis, records, billing, and examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____
[ ] Child(ren)_____
[ ] Other_____

[ ] Limited Information can be released, i.e. review of appointments and instructions given, oral hygiene counseling, scheduling of future appointments to anyone accompanying the patient to his/her appointment.

[ ] Information is not to be released to anyone.

Messages

Messages may be left by employees of* GKG Orthodontics** or ***an Automated Messaging Service

Please call
[ ] cell #: _____ [ ] home #:_____ [ ] other #:_____

If unable to reach me:

[ ] you may leave a detailed message
[ ] you may text a detailed message
[ ] please leave a message asking me to return your call
[ ] _____

Emails

[ ] I Authorize **GKG Orthodontics** to email me pictures of the patient(s) and x-rays, appointment reminders, school excuses, and statements and receipts.

Email address: _____

Authorization:

Patient Signature: _____ Date: _____

If under the age of 18: Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: _____

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