GENERAL POLICY FOR RELEASE OF PROTECTED HEALTH INFORMATION

The Health Insurance Portability and Accountability Act allows individuals to request restrictions on uses and disclosures of their protected health information. Further, the individual may request confidential communications may be made by alternative means.

Patient Name_____ Date of Birth_____

Dr. Regan has my permission to release protected health information to the following person(s):

1._____ Relationship_____

2._____Relationship_____

3._____Relationship_____

___ I do not wish to have any protected health information given to anyone but me.

___ Messages may be left on answering machine at home as long as we are sure that it is the correct telephone number.

___ Messages may be left on voice mail at work as long as we are sure it is the correct and secure voice mail.

___ Information may be mailed to my home. ___ Information may be mailed to my work address.

Signature_____ Date_____

Minor Children

The above named patient is a minor child for whom I am responsible. I understand that care will not be provided until after my approval has been requested and received.

Signature_____ Date_____

I hereby acknowledge that I have been given a copy of DeAun Silva Regan, D.D.S.'s Notice of Privacy Practices, have read and had an opportunity to discuss it with a staff member.

Initial _____

Special Note: *We will be pleased to assist you in whatever manner we can to help with your insurance and will be happy to file your insurance claims for dental care. However, it is ultimately your responsibility to know your policy and resolve any differences that may develop regarding coverage or lack thereof. Should your insurance policy not include dental care, you are financially responsible for any services provided by this office.*