YOUR SIGNATURE IS NECESSARY FOR US TO:

1. ***Process all insurance claims,***
2. ***To ensure payment for services rendered,***
3. ***To release medical information to insurance companies, AND***
4. ***To release and/or obtain information to/from other medical/dental providers, when necessary, for your treatment.***

I, authorize the release of all medical information necessary to process my claims and I authorize the release of this same information, when necessary, to other providers rendering medical/dental care

Patient Signature: _____ **Date: _____**

Responsible Party: _____

(Parent, if Minor ONLY)

Office Use Only:

Witness: _____

Health Information Release Form

In order to assist you in receiving your health information from our office, please complete this form.
I, authorize the persons listed below to have access to any and all of my health information. This office is permitted to share any information with them that is disclosed during office visits.

Persons authorized to receive my information (full name, relationship and phone number):

Name **Relationship** **Phone Number**

_____

_____

_____

_____

_____

__ You may notify me or the parties listed above with any information regarding my treatment including appointment reminders, treatment information or prescriptions as follows:

Please mark below which you authorize

__ Message on home answering machine

__ Message work voicemail

__ Message on cell phone

I understand and direct that this authorization will remain in effect until it is revoked by me in writing.

_____ _____

Print Name **Patient Signature**

_____ _____

Patient Date of Birth **Today's Date**

Notice of Privacy Practices Acknowledgement

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about your privacy practices, our legal duties and your rights concerning your health information.

I _____ have been given a copy of the Notice of Privacy Practice by the office of Dr. Lee Sheldon. I have read and understand this information.

_____ _____

Patient Print Name Patient Signature

_____ _____

Patient Date of Birth Today's Date

Office Use Only:

_____ _____

Witness Print Name Witness Signature