Personal Health Information (*PHI) Release Form

Date: _____

I _____ (please print your full name) do hereby authorize Aland Family Dentistry to share my *Protected Health Information* (***PHI**) with the below listed entities. I understand that they will have full access to my account and treatment records in addition to all personal information in my files digital and physical. I also agree they have the authority to make changes to my personal and insurance information and request copies of digital and/or physical records.

Please print the full name and date of birth of those authorized to access your ***PHI**

1) _____ DOB:_____

2) _____ DOB:_____

3) _____ DOB:_____

_____I have read and understand Aland Family Dentistry's HIPPA privacy notice based on the model developed by the U.S. Department of Health and Human Services Office for Civil Rights.

_____I authorize Aland Family Dentistry to provider my insurance company with any and all information to process my claims for payment, and or my dependant(s) claims.

_____I authorize my insurance company to release all benefit payments for myself and/or dependant(s) directly to Aland Family Dentistry and/or Dr. Aland.

_____This notice is effective for 2 years from the date it is signed. If I want to make any changes to this document or those entities information is released to I must do so in writing.

Signature:_____Date:_____