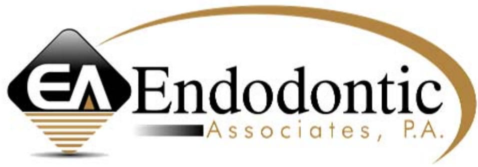

HIPPA acknowledgement and Medical Release

I, ____ authorize
Patient Name

Endodontic Associates, PA

to **release** my dental records and billing/account history to:

Name: ____

Relationship: __________________

Address: ____

Home Phone: __________________

Mobile Phone: _________________

Email: ____

Name: ____

Relationship: __________________

Address: ____

Home Phone: __________________

Mobile Phone: _________________

Email: ____

Patient Signature: ____

Cool Springs Office: 8112 Isabella Lane, Suite 105, Brentwood, TN 37027 * Telephone 615.371.9478
Hill Center at Green Hills Office: 4027 Hillsboro Pike, Suite 805, Nashville, TN 37215 * Telephone 615.383.4455