HIPAA 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:_____