Notice of Our Privacy Practices
Permission to Release Information to Another Individual
Consent to Discuss Treatment

HIPAA (Health Insurance Portability and Accountability Act)
January 1, 2007 (Updated January 1, 2014)

I have received a copy of Samuels Dental Arts P.C. Notice of Privacy Practices.

Indicate your relationship to the patient: Patient _____ Guardian/Representative _____

Print Name: _____

Signature: _____ Date: _____

I give Samuels Dental Arts P.C. permission to release diagnostic test results to, and discuss protected health information with the following person(s):

Name:	Relationship:
Name:	Relationship:
Name:	Relationship:
Name:	Relationship:
Name:	Relationship:

I give Samuels Dental Arts P.C. permission to leave any protected health information on an answering machine or voicemail. Initial: _____

I give Samuels Dental Arts P.C. permission to send my records, including films, through email. Initial _____

I consent to have Dr. Peter J. Samuels and/or Dr. Julie C. Berger discuss my dental treatment with insurance companies, referring doctors, referral doctors, dental colleagues, physicians, process my photos with an outside laboratory, and to use my case in lectures and teaching. I give consent for Samuels Dental Arts office staff to confirm my dental appointments with my spouse or family member or by answering machine and by reminder postcard. I understand Samuels Dental Arts P.C. will file my insurance form electronically and I do give consent for this submission.

Indicate your relationship to the patient: Patient _____ Guardian/Representative _____

Print Name: _____

Signature: _____ Date: _____

This authorization is valid until a new release form is completed.

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