**MEDICAL RELEASE AUTHORATION**
(HIPAA)

Name
Patient Date of Birth:
Patient SS#:

I authorize Joseph J. Perry, DDS, to communicate with outside physicians and their staffs, other dentists and their staffs, pharmacists and their staffs, insurance company's and any other health care professionals, concerning my medical/dental health and billing/account records held by:

Beeville Dental Care
Joseph J. Perry, D.D.S.
1703 N. St. Marys
Beeville, Texas 78102
(361) 358-9780
800-879-0109

I further authorize the electronic, digital, or verbal communications of records or information between Joseph J. Perry, D.D.S., and any insurance company, physicians office, dental office, or any other healthcare agency associated with the dental treatment. All treatments, accidents, and illnesses are covered by this release. I further agree to hold harmless the staff and officers of Joseph J. Perry, D.D.S., concerning the release of any dental/medical record(s).

_____ _____
Patient Signature Date

_____ _____
Witness Date

I **do/do not** authorize the release/discussion of sensitive medical records or those records whose disclosures is protected by law. These include records concerning chemical dependency. I understand that refusal to release this information may effect the standard of care available to the patient as the staff would be limited in disclosure of my complete medical condition.

_____ _____
Patient Signature Date