Heritage Oak Dental
(916) 626-4050

Personal Representative Authorization Release Form
Health Information Protected Under HIPPA

I authorize this facility to speak to the following family members or my personal representative regarding:

All medical information, including but not limited to records pertaining to examinations, treatments, consultations, billing records, x-rays and reports, history, laboratory findings, reports, treatment records, diagnosis and prognosis and records, notes and any other non-medical information in my file.

Only the following types of information: ____

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The above medical information shall only be released to the following persons:

Name of Personal Representative	*Relationship*	*DOB*	*Phone#*
______________________	______________	__________	__________
______________________	______________	__________	__________
______________________	______________	__________	__________

I understand that I may terminate this Medical Authorization form. I must notify this facility in writing regarding termination and effective date.

This authorization shall remain valid (check one)

Until revoked in writing.

Until _______________, 20_____

Name: ________________________________

Signature: ________________________________

Date: ____________________

Office Use Only

Witness: ____________________________ Scan Initials: _____