STIEBEL&BAKER
DENTISTRY

PATIENT AUTHORIZATION FORM

Authorization to Release Medical Information

Under the requirements for patient privacy and HIPAA related laws, we are not allowed to share your personal, medical/dental, or account information without your consent. If you would like us to be able to share this private information with a close friend or family member, we need your permission. Please sign the authorization below.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance upon your prior consent.

I authorize Stiebel & Baker Dentistry to release my records and any information requested to the following individuals.

1. ___________________________________ Relation to Patient:____________________

2. ___________________________________ Relation to Patient:____________________

3. ___________________________________ Relation to Patient:____________________

4. ___________________________________ Relation to Patient:____________________

______________________________ ___________________________________ ____________________

Printed Name Signature Date

(540) 869-2737 (540) 869-2925
1021 Aylor Rd, Stephens City, VA 22655
contact@drbakerdentistry.com