COMPASS DENTAL
NAVIGATION TO YOUR BEST ORAL HEALTH

1330 4th Street Drive NW
Hickory, NC 28601

Authorization to Release & Discuss Dental Information the HIPAA privacy law requires that we are only authorized to communicate with patients themselves, guardians, insurance providers and primary care physicians, unless we have authorization in writing by the patient to communicate with others on their behalf. Please provide all family members or friends you want us to be able to speak with. Spouses are not automatically included; their names must be explicitly stated below. You may opt out by checking the "Do not Release Information" box below. Authorization to speak with family/friend (including spouse) I give the following named person(s) authorization to take messages or speak with the office of Ryan Sigmon DMD dba Compass Dental, on my behalf regarding (please check all items authorized).

Release Authorized Information to the following:

Name of authorized person(s):

_____

Relationship: _____

Phone number: _____

Appointments __ financial __ Dental Treatment __ Insurance __ other__

Name of authorized person(s):

_____

Relationship: _____

Phone number: _____

Appointments __ Financial __ Dental Treatment __ Insurance __ other __

Authorization to Leave Health Information by Alternate Means I authorize Ryan Sigmon, DMD and staff to use the following telephone numbers provided on the Patient Registration Form to leave messages on voice mail for reminder calls and other patient matters. ___Home Phone ___Work Phone___Cell Phone

OR

___DO NOT RELEASE INFORMATION TO ANYONE

I understand that my express consent is required to release any health care information. With my signature below, I acknowledge and understand that this information will be kept in my medical record and the above parameters will remain in effect until revoked by me in writing. It is my responsibility to notify my healthcare provider(s) should I wish to change one or more contacts listed above.

Patient's Name: _____ Date of Birth _____

Please Print Name _____

Signature of patient or Guardian_____ Date_____