Gemma T. Dalton, D.D.S.
2307 Central Drive, Bedford, TX 76021

DISCLOSURE AUTHORIZATION

Due to Health Insurance Portability and Accountability Act (HIPPA) of 1996, the following information must be filled out by each patient.

Date: _____

I authorize Gemma Tanglao Dalton, D.D.S. and associates, to release any of my medical or insurance information necessary to process my medical claims and coordinate or manage my health care.

In the event a family member or caregiver attends your office visit and is in the exam room at the time of your evaluation and/or treatment, I give Gemma Tanglao Dalton, DDS, associates and employees my permission to discuss freely, my condition, treatment, or diagnosis with that person. **YES/NO**

HOME PHONE: _____ MAY WE LEAVE A MESSAGE: **YES/NO**

WORK PHONE: _____ MAY WE LEAVE A MESSAGE: **YES/NO**

CELL PHONE: _____ MAY WE LEAVE A MESSAGE: **YES/NO**

PAGER PHONE: _____ MAY WE LEAVE A MESSAGE: **YES/NO**

E-MAIL: _____ MAY WE LEAVE A MESSAGE: **YES/NO**

May we leave a message at one of the numbers listed above about appointments with this office?

YES/NO **HOME / WORK / CELL / PAGER / E-MAIL**

With whom may we discuss or release information about your care, treatment, or diagnosis?

_____ **Relationship** _____

_____ **Relationship** _____

_____ **Relationship** _____

This authorization shall remain in effect from the date signed below until:

☐ _____(expiration date or event)

OR

☐ No Expiration

Printed Name: _____ Signature:_____

Relationship to Patient (if signed by personal representative of Patient): _____

Date:_____