GibbsDentistry

Kenneth W. Gibbs, DMD, PA | Meridith Gibbs, DMD | M. Breckenridge Gibbs, DMD
901 Pine Tree Drive | New Bern, NC 28562 | Tel. (252) 633-5544 | Fax: (252) 633-9788 | www.gibbsdentistry.com

HIPAA FORM

Patient full name (*please print*):____

Patient Street Address:____

City:______________________________State:_____________ Zip:________________

Home Phone:__________________________ Cell Phone:______________________________

I authorize **Gibbs Dentistry** to release my patient information, other than to my insurance company, to the following person(s):

Name:____

Relationship: _______________________________________

Address:____

Phone: ____

Name:____

Relationship: _______________________________________

Address:____

Phone: ____

I understand that I have the right to revoke this authorization at any time. My revocation must be in writing and provided to **Gibbs Dentistry.**

I am signing this form voluntarily and I understand that failure to sign this authorization form will result in the non-release of my protected health information.

Patient signature:____ Date:____________

Parent/Guardian Signature:____________________________________ Date:____________