Dental Information Release

I give my permission to Sunfish Dental/Nicole Tripp, DDS PLLC to allow the undersigned to speak with the dentist/dental staff in regards to my medial history, dental care, dental treatment and my account. This form is valid until I request in writing that it be voided. This is in compliance with HIPAA (Health Insurance Portability and Accountability Act) to protect patient's confidentiality of medical information.

I give my permission to Sunfish Dental/Nicole Tripp, DDS PLLC to allow the undersigned to pick up my prescriptions and any other hard copy or electronic records and discuss account information from the office if the need arises.

Name: _____ Relationship:_____

Name: _____ Relationship:_____

Name: _____ Relationship:_____

Name: _____ Relationship:_____

_____ _____

Signature of Patient Date

For office use only:

We attempted to obtain written acknowledgement of receipt of our Office and Privacy Practices but acknowledgement could not be obtained because:

____Individual Refused to Sign

____Communication Barriers Prohibited obtaining acknowledgement

____An emergency situation prevented us from obtaining acknowledgement

____Other (Please Specify) :_____