

HIPAA
Medical Record Release Authorization

I _____

Here by authorize _____ to release my
medical/dental records to:

Morrell Dental
403 S 11th St, Suite 200
Boise, ID 83702
(208) 342-3440
Fax: (208) 336-4740
morreldental@yahoo.com

Signature of Person Receiving:

Date:

This release may be done: (circle all that apply)

In Person

By Facsimile

By US Mail

By Overnight Courier

By EMAIL

Patient Name:

Signature:

Date: