Springhill Dental and Orthodontics
637 NW Hickory St #110, Albany, OR 97321
(541) 406 3500
springhilldentalalbany.com

HIPAA ? RELEASE OF INFORMATION AUTHORIZATION FORM

Patient Name: _____ **DOB:** _____
FIRST LAST

In compliance with federal and state law, the release of information for any person 18 years or older (including the information regarding a spouse or adult child), must first be authorized. Authorization includes the signature of the individual authorizing the release of their information. Information will not be available to anyone other than the covered patient (i.e., a member, a spouse, or any dependent age 18 or older) without first having this Release of Information Authorization on file. For example, if a subscriber calls about the status for a claim on a 19-year old dependent, that information will not be given to the subscriber without the written consent of the dependent. The same situation holds true for spouse-to-spouse information. However, parents do have a right to information on children under the age of 18 without

I want to provide the authorization: ☐ Yes ☐ No

Information Regarding Person Authorizing Releasing His/Her Information

Name of person authorizing release:

Date of Birth person authorizing release:

Personal Information to be released:

The above information may be released and/or received by:

The following is an authorization allowing Springhill Dental and Orthodontics to release information to whomever you designate. Springhill Dental and Orthodontics is authorized to make the disclosure of my benefits information, claim(s) status, claim(s) history, general claim information, dentist information, lab cases, and enrollment information, unless otherwise specified to the following individual(s) or organization(s):

Name of person/organization that the office may release my information to:

Relation of person/organization that the office may release information to:

Phone number of person/organization that the office may release information to:

I want to add a second person/organization: ☐ Yes ☐ No

Name of person/organization that the office may release my information to:

Relation of person/organization that the office may release information to:

Phone number of person/organization that the office may release information to:

I want to add a third person/organization: ☐ Yes ☐ No

Name of person/organization that the office may release my information to:

Relation of person/organization that the office may release information to:

Phone number of person/organization that the office may release information to:

I want this consent to:

Authorization Consent

I understand that consent may be revoked by me at any time in writing. I understand why I have been asked to disclose this information and am aware that my patient rights are identified in the practices Notice of Privacy Practices.

Patient/Guardian Signature: _____ Date: 09/16/2025