ALEXANDRIA OLD TOWN DENTAL

HIPAA AUTHORIZATION/CONSENT FORM.

I _____, will allow Alexandria Old Town Dental Office Staff to discuss my medical conditions and my account with the following person (s).

1. _____.
2. _____.
3. _____.
4. _____.

The following number is a secure and confidential phone number that Alexandria Old Town Dental staff may leave a message regarding my appointment and/or any other information that may have be related to me. _____.

I will notify this office in writing anytime that I wish to change any of the information above.

Signature: _____.

Date: _____.