

**Dental Records/Information  
Use and disclosure Consent Form**

It is the policy of the federal government to protect the rights of each patient's privacy. As set forth in the Notice of Privacy Practice, no patient's information is disclosed without the patient's consent. Under the Health Insurance Portability and Accountability Act (HIPAA) any patient 15 years and older is entitled to privacy of information. This means that any parent or guardian of a patient 15 years or older is not allowed to access to the minor's information without consent of the minor.

Purpose of consent: By signing this form, you (or the patient you represent) will consent to our use and disclosure of your (or the patient you represent) 1) Health information 2) X-rays 3) Dental Records 4) Financial Information.

Patient Name: \_\_\_\_\_

Family Members: \_\_\_\_\_

I hereby authorize (previous provider) \_\_\_\_\_  
To release a copy of the dental information for the patient and/or family above to:

Kevin R. Morich DMD, PC  
Macadam Dental  
5331 SW Macadam Ave Suite #254  
Portland, OR 97239  
[office@macadamdental.com](mailto:office@macadamdental.com)

By checking the spaces below, I specifically authorize the release of the following dental records, if such records exist:

- All dental records (xrays, treatment notes)
- Xrays only
- Financial information/agreements
- Information disclosed from the treatment plan
- Billing Inquires

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Macadam Dental, P.C.  
5331 SW Macadam Ave Suite 254  
Portland, OR 97239  
503-243-6111  
[office@macadamdental.com](mailto:office@macadamdental.com)