Rugby Dental Office

Release of Information

(HIPAA Release Form)

Patient Name(s): DOB:

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Release of Information:

I authorize the release of my x-rays and / or records along with any family members listed above to:

Rugby Dental Office, P.C.
201 7th Street SW, Suite 1
Rugby, ND 58368

This Release of Information will remain in effect until terminated by me in writing.

Signed:______________________________ Date:______________

701.776.5884 • 201 7th St. SW, Suite 1 • Rugby, ND 58368
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rugbydental@gondtc.com