Health Information Release Form

The policy and practice of Dr. Konvalinka is to maintain the privacy of his patient's Private Health Information consistent with the Notice of Privacy Practices that you have read and acknowledged previously. Some patients find it useful to allow family members or other trusted individuals access to some or all of the information we hold. Please read the following and choose one or more of the options below to allow us to release the appropriate information to those you wish to access it.

Account Information Only

The individuals listed below may be given information concerning the financial transactions incurred in my dental care by Dr. Konvalinka and his staff, which may disclose particular procedures that were performed or are contemplated and payments for that work. By choosing this option I understand that Dr. Konvalinka and his staff may not disclose to them other private health information, but that the procedures that were performed or are contemplated may allow the named individuals below who are now being given permission to access it to make inference about some aspects of my health information. This permission will be in effect until I notify Dr. Konvalinka in writing that I would like to rescind this understanding.

Listed Individuals

Name: _____ Relationship:_____

Name: _____ Relationship:_____

Patient Name:_____

Patient Signature: _____ Date: _____

All Protected Health Information

The individuals listed below may be given any and all information [financial, health, personal] related to the dental care rendered by Dr. Konvalinka and his staff. In essence all information is open to the below named individuals. By choosing this option I understand that Dr. Konvalinka and his staff may disclose any private health information, dates of treatment, clinic notes, communications and any contemplated treatment. This permission will be in effect until I notify Dr. Konvalinka in writing I would like to rescind this understanding.

Listed Individuals

Name: _____ Relationship:_____

Name: _____ Relationship:_____

Patient Name:_____

Patient Signature: _____ Date: _____