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PRIVACY RELEASE

Patient Name: _____

Please print

The privacy of your health information is important to us, please review this Release carefully. We are required by applicable federal and state law to maintain the privacy of your health information. Therefore this form must be **signed**, if you wish us to release any information, including but not limited to your appointment times, treatment, or financial information to **any** other person.

I HEREBY AUTHORIZE PECOS DENTAL to release my protected health information regarding my dental treatment/ records to the individual(s) listed below:

1. _____

2. _____

3. _____

I understand this Release will remain in effect until I notify Pecos Dental in writing that I wish to withdraw my permission.

Signature

Date