VALLEY DENTAL

Authorization to Release Information To Others

Many of our patients allow family members or others close to them to call and request information regarding their condition and/or treatment. Under the requirements for HIPPA (Health Insurance Portability and Accountability Act), we are not allowed to give this information to anyone without the patient's consent. If you wish to have your dental condition and/or treatment disclosed to someone else, please indicate below. You have the right to revoke this consent, in writing, except where we have already made disclosures in compliance with your prior consent.

- ☐ Yes. You May disclose my information to the below listed person(s)
- ☐ No. You may not disclose my information to anyone but me

Approved Persons:

1. Name:_____ Relationship:_____
2. Name:_____ Relationship:_____
3. Name:_____ Relationship:_____

_____ ___/___/___

Patient Signature Date

_____

Printed Patient Name

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For Office Use Only:

We were unable to obtain the patient's written acknowledgment of our Notice of Privacy Practices due to the following reason(s):

- ☐ The patient refused to sign
- ☐ Communication/language barriers
- ☐ Emergency situation
- ☐ Other. Please Explain:_____