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.

You do not need to list other medical professionals such as your medical doctor. List if you choose Spouses, parents & step-parents, family members, or significant others.

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

Approved Persons:

- Name:_____Relationship:_____
- Name:_____Relationship:_____
- Name:_____Relationship:_____

_____ ___/___/___

Signature of Patient or Guardian Date

_____

Printed Patient Name(s)-list any and all children