# Authorization for Release of Private Health Information

________________________________________
Patient Name

Please check the appropriate boxes below to authorize us to contact you or leave messages to discuss or disclose your protected dental health information as needed for your treatment, fees, billing and appointments with us. (Please check all that apply.)

Cell __ Voice Mail __ Email __ Text Message __ Work #____________ Other:_________

The purpose of the authorization below is to give us permission to discuss treatment with family or other persons whom you wish to be informed about your past, present or future treatment in this office.

In keeping with HIPAA laws concerning patient privacy, I authorize this office to release my private health information such as x-rays, diagnosis, health history, dental history or anything pertinent to my dental treatment in this office to the persons listed below.

Spouse : ________________________________________
Name

Parent: ________________________________________
Name

Other: ____________________________ ________________
Name Relationship

<u>Rights of the Patient</u>

You are not required to sign this authorization unless you want your dental health information released to the people indicated above. Your treatment will not be denied if you do not sign this form. However, we cannot release any information about appointments or treatment to any person that is not listed on this form.

You have the right to inspect or receive a copy of the protected health information to be disclosed by us upon request. You have the right to revoke this authorization at any time by notifying the person at the front desk.

The information disclosed by this office may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA. This practice its employees are hereby released from any legal responsibility or liability for disclosure of protected health information to the extent indicated and authorized herein.

________________________________ ____________________
Signature of Patient (or Guardian if applicable) Date