

Authorization for Release of Information to Family Members Patient

Name _____

Date of Birth _____

Many of our patients allow family members such as their spouse, parents or others to call and request dental or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your dental or billing information released to family members you must sign this form. Signing this form will only give information to family members indicated below.

I authorize Hometown Family Dental to release my medical and/or billing information to the following individual(s):

1. _____ Relation to Patient: _____

2. _____ Relation to Patient: _____

3. _____ Relation to Patient: _____

Authorization to Leave Detailed Messages

Occasionally it is necessary for the staff of Hometown Family Dental to leave messages for patients. The purpose of these messages are to notify the patient that we would like to discuss treatment needs, billing purposes or to ask a patient to call back regarding an issue or concern. To expedite the receipt of the needed information, please indicate below if you would like to give consent to leave detailed messages. Please mark your preference below:

_____ I authorize Hometown Family Dental to leave detailed voicemails. This is the phone # I would like messages left: _____

_____ I authorize Hometown Family Dental to send detailed emails. This is the email address I would like messages sent: _____

_____ I do not want any detailed messages left on voicemail or sent via email.

Patient Information I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed. I understand that information disclosed to any above authorized recipient or voicemail or email is no longer protected by federal or state law and may be subject to redisclosure by the above recipient or someone who has access to your voicemail or email. You have the right to revoke this consent in writing.

Signature: _____ Date: _____