

Authorization for Release of Information to Family Members

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 **Miller Family Dentistry** to release my dental and/or billing information to the following individual(s):

1. _____ Relation to Patient: _____
• Phone: _____ Permission to leave a message Yes No
2. _____ Relation to Patient: _____
• Phone: _____ Permission to leave a message Yes No

I understand that information disclosed to any above authorized recipient is no longer protected by federal or state law and may be subject to re-disclosure by the above recipient. You have the right to revoke this consent in writing.

Signature: _____ Date: _____

