DENTAL ASSOCIATES OF DELAWARE

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 medical/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 medical/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 Dental Associates of Delaware to release my medical/dental and/or billing information to the following individual(s):

1). _____ Relationship to Patient: _____

2). _____ Relationship to Patient: _____

3). _____ Relationship to Patient: _____

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 recipient is no longer protected by federal or state law and may be subject to redisclosure by the above recipient.

You have the right to revoke this consent in writing at any time.

Signature: _____ Date: _____