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 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 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 JOHN F. DAHM FAMILY DENTISTRY TO RELEASE MY MEDICAL AND/OR BILLING INFORMATION TO THE FOLLOW INDIVIDUAL(S):

1. ____________________________ RELATIONSHIP TO PATIENT: ________________

2. ____________________________ RELATIONSHIP TO PATIENT: ________________

3. ____________________________ RELATIONSHIP TO PATIENT: ________________

4. ____________________________ 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.

PATIENT/GUARDIAN SIGNATURE: ______________________ DATE: ________