Periu Family Dentistry

PATIENT AUTHORIZATION FORM

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, signification other, parents or children to call and request the results of tests, procedures, and financial information. Under the requirements for H.I.P.A.A we are not allowed to give this information to anyone without the patient's consent. If you wish to have your dental/medical information, any diagnostic test results, and/or financial information released to any family members you must sign this form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Periu Family Dentistry to release my records and any information requested to the following individuals:

1. _____ Relation to Patient: _____
2. _____ Relation to Patient: _____
3. _____ Relation to Patient: _____
4. _____ Relation to Patient: _____

Authorization Regarding Messages
(Please check ALL that apply)

_____ I authorize you to leave a detailed message on my home or cell number regarding appointments

_____ I authorize you to leave a detailed message on my home or cell number regarding dental treatment, test results, or financial information

_____ I authorize you to leave a message with anyone who answers the phone

_____ Messages may only be left with _____

Relationship: _____

Patient Name: _____

Patient Signature: _____ Date: _____