LaFevers
DENTAL TEAM

Authorization to Release & Discuss Dental Information

How are we able to communicate with you (for ALL matters):

☐ **Text** ☐ **Call** ☐ **Voicemail** ☐ **Email** ☐ **ALL**

The HIPAA privacy law requires that we are only authorized to communicate with patients themselves, guardians, insurance providers and primary care physicians, unless we have authorization in writing by the patient to communicate with others on their behalf. Please provide all family members, friends, or caregivers you want us to be able to speak with. **Spouses are not automatically included; their names must be explicitly stated below**. You may opt out by checking the "Do NOT Release Information" box below.

I give the following named person(s) authorization to take messages or speak with the office of LaFevers Dental Team, on my behalf regarding (**please check all items authorized**).

Name of authorized person(s): _____ Relationship _____
Phone number _____

__Appointments __ Financial __ Dental Treatment __ Insurance __ Other (explain) _____

Name of authorized person(s): _____ Relationship _____
Phone number _____

__Appointments __ Financial __ Dental Treatment __ Insurance __ Other (explain) _____

___DO NOT RELEASE INFORMATION TO ANYONE

I understand that my express consent is required to release any health care information. With my signature below, I acknowledge and understand that this information will be kept in my medical record and the above parameters will remain in effect until revoked by me in writing. It is my responsibility to notify my healthcare provider(s) should I wish to change one or more contacts listed above.

- You can review or copy the information that will be used ore released as described in this authorization
- The recipient of the information could use or release it in a way that federal or stat laws do not protect. This practice is not responsible for the privacy or security of your health information after it is sent to those listed on this authorization.
- I understand that emails and texts are not always secure ways to communicate and could intercepted and read by a third party. I am willing to accept this risk.
- This practice is not responsible for the privacy or security of your health information once it is sent to the recipient listed above.

Patient's Name: _____ Date of Birth _____

Signature of Patient or Authorized Representative: _____

Date Signed: _____