Gregory S. Brya, DDS, PLLC / Patrick S. Sweeney, DDS

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AUTHORIZATION FOR RELEASE OF INFORMATION TO FAMILY MEMBERS

Patient Name: ______________________ * ______________________ * ____ ______________________

Last First MI Preferred Name

Date of Birth: * __________

Disclosure

Many of our patients allow family members such as their spouse, parents, guardians, children or others to call and request medical, dental treatment 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 treatment or billing information released to family members, you must sign this form.

I authorize Gregory S. Brya, DDS to release my medical, dental treatment or billing information to the following individuals:

Name: *

____

____

Relationship to Patient: *

☐ Spouse ☐ Child ☐ Parent ☐ Guardian ☐ Other

Name:

____

____

Relationship to Patient:

☐ Spouse ☐ Child ☐ Parent ☐ Guardian ☐ Other

Name:

____

____

Relationship to Patient:

☐ Spouse ☐ Child ☐ Parent ☐ Guardian ☐ Other

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.**

Signature of patient, parent or guardian (responsible party):

Signature ______________________________________ **Date** __________

Date: * __________

Response Date: __________