

# Gregory S. Brya, DDS, PLLC

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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 re-disclosure 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:** \_\_\_\_\_