****** PERMISSION TO RELEASE CONFIDENTIAL MEDICAL OR DENTAL INFORMATION TO A **** FAMILY MEMBER, FRIEND, OR LEGAL REPRESENTATIVE**

IMPORTANT NOTICE: The law prohibits release of confidential Medical or Dental Information to any entity without the written, voluntary consent of the undersigned patient.

Name of Patient:____**Date of Birth:**____________
(Please print patient's first and last name)

_______________ **I do not want any information given to anyone other than myself.**
(Please initial)

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Please initial the box below to specify the information you are authorizing us to communicate.

I authorize Shull Family Dentistry to:

______________ **Discuss information regarding my appointment**

______________ **Leave detailed phone messages**

______________ **Discuss my medical or dental condition**

______________ **All of the above**

Please write in the names of persons who are authorized by you to receive your Protected Health Information (verbally and/or in writing), and their relationship to you *(the patient):*

________________________________ ________________ ________________
(Print first and last name) *(Phone #)* *(Relationship)*

________________________________ ________________ ________________
(Print first and last name) *(Phone #)* *(Relationship)*

________________________________ ________________ ________________
(Print first and last name) *(Phone #)* *(Relationship)*

This Authorization will expire one year from the date it was signed. Please be prepared to update this Authorization once a year which is required by the HIPAA privacy law regulations. This Authorization can be revoked at any time by you (the patient) in writing at any time.

I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

____ ________________
(Signature of Patient or Legal Representative) *(Date)*

____ ________________
(Print First and Last Name of Legal Representative, if applicable) *(Date)*
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