## HIPAA - AUTHORIZED DISCLOSURE FORM

Many of our patients allow family members such as their spouse, parents, or others to call and request/discuss dental or billing information. Under the requirements of HIPAA we are not allowed to disclose this information without the patient's consent. If you wish to have your dental or billing information released to anyone other than yourself, you must sign this form. Signing this form will only give permission to disclose information to those indicated below.

I, ________________________________________, give permission to Williams Family Dentistry to disclose and release my protected health information to:

| Name(s): | Relationship: |
| --- | --- |
| ______________________________ | ______________________________ |
| ______________________________ | ______________________________ |
| ______________________________ | ______________________________ |

This dental health information may be used to enable the person(s) I authorize to know and understand my condition and my treatment or treatment options, for payment purposes, or related reasons.

This authorization shall be effective indefinitely. NOTE: You may revoke this authorization at any time by notifying Williams Family Dentistry in writing.

______________________________________
Name of the Individual Giving this Authorization

______________________________________ ______________________
Signature of the Individual Giving this Authorization Date