HIPPA Authorization to Release & Discuss Dental Information

The HIPPA 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 or person(s) 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 Go Smiles Dentistry on my behalf regarding (please check all that apply)

- Name of authorized person: _____ Relationship: _____
  Phone number: (_____) _____ - _____
  ☐ All information regarding my dental care
  or just ☐ Appointments ☐ Financial ☐ Dental Treatment ☐ Insurance
- Name of authorized person: _____ Relationship: _____
  Phone number: (_____) _____ - _____
  ☐ All information regarding my dental care
  or just ☐ Appointments ☐ Financial ☐ Dental Treatment ☐ Insurance
- Name of authorized person: _____ Relationship: _____
  Phone number: (_____) _____ - _____
  ☐ All information regarding my dental care
  or just ☐ Appointments ☐ Financial ☐ Dental Treatment ☐ Insurance

☐ DO NOT RELEASE INFORMATION TO ANYONE

I understand that my express consent is required to release any healthcare 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 should I wish to change one or more of the contacts listed above.

Printed Patients Name: _____ Patient Date of Birth _____/_____/_____

Signature of Patient or Authorized Representative: _____

Date: _____