PATIENT RELEASE AUTHORIZATION FORM

Authorization to release information to family members

Many of our patients request that their family members such as spouses, significant others, parents, or children be allowed to call to discuss treatment options, procedures, post op instructions, financial information etc. on their behalf. Due to HIPAA laws, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your dental treatment information and/or financial information released to any family members, you must sign this form.

You have the right to revoke this consent at any time, in writing, except where we have already made disclosures in reliance on your prior consent

I hereby authorize Dental Flossophy to release the information noted below by check marks to the following individuals as requested

1. Name _____

   Relationship to patient _____

   Contact information _____

2. Name _____

   Relationship to patient _____

   Contact information _____

Authorization regarding conversations/messages (check all that apply)

____ I authorize you to discuss dental appointments and treatment plans and options along with post operative instructions

____ I authorize you to discuss financial information including insurance, payment plans, out of pocket expenses etc.

_____ _____ _____

Patient Name (please print) Patient Signature Date