HIPAA Privacy Authorization Form

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPAA, we are not allowed to give the information to anyone without the your consent. If you wish to have your medical or billing information released to anyone you must sign this form. Signing this form will only give consent to release this information to the person(s) indicated below. This consent will not allow Sky Dental to release any other information.

You have the right to revoke this consent anytime in writing.

I authorize/allow Sky Dental to release my medical and/or billing information to the following individual(s):

1.)_____ Relationship to Patient: _____

2.)_____ Relationship to Patient: _____

3.)_____ Relationship to Patient: _____

Patients Name:_____

Patients Signature:_____ Date:_____

Authorization to Leave Messages with Household Member/Answering Machine:

Occasionally, it is necessary for the staff at Sky Dental to leave a message for patients. The purpose of these messages is to remind patients that they have an appointment, to notify the patient that the staff would like to discuss treatment, schedule future appointments, or to ask a patient to call regarding an issue or concern. At no time will a representative of Sky Dental discuss your medical condition without your consent.

You have the right to revoke this consent anytime in writing.

Patients Name:_____

Patients Signature:_____ Date:_____