

# Schall Family Dental, Inc.

112 East Washington St Monticello, Il. 61856 217-762-4366

## AUTHORIZATION FOR RELEASE OF INFORMATION TO FAMILY MEMBERS/CAREGIVERS

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Many of our patients allow family members such as their spouse, parent or others to call and request dental/medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your dental/medical or billing information released to any family member or caregiver you must sign this form. Signing this form will only give information to those listed below as well as to the signee.

I authorize Schall Family Dental, Inc. to release my dental/medical and/or billing information to the following individual(s):

1. \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

2. \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

3. \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

4. \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

**Patient Information** I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed. I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to re-disclosure by the above recipient. You have the right to revoke this consent in writing.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_