Authorization to Disclose Health Information to Family Members and Friends

Patient Name _____Date of Birth_____/_____/_____

I hereby authorize Armstrong Family Dentistry, PC ("AFD") to release my patient health information as described below:

		Type of Information Allowed to Disclose (Check one or both)		Method of Disclosure (Check one or both)	
Name	Relationship	Dental	Billing	By Phone	In Person

Protected Health Information ("PHI") may include information/documents regarding dental/medical treatment of the patient including, but not limited to, diagnosis, procedures, treatment plans, appointments and test results; account and billing information including, but not limited to, account balances, payments and payment arrangements, insurance claims status, and third party financing.

I understand that the Health Insurance Portability and Accountability Act of 1996, and its implementing regulations ("HIPAA") govern the terms of this Authorization. I understand that I have the right to revoke this Authorization, at any time prior to the Practice's compliance with the request set forth herein, provided that the revocation is in writing. I further understand that additional information relating to the exceptions, the right to revoke and a description of how I may revoke this Authorization is set forth in AFD's Notice of Privacy Practices. I understand that any revocation must include my name, address, telephone number, date of this Authorization and my signature; and that I should send it to the attention of the "HIPAA Compliance Officer".

I understand that I am not required to sign this Authorization and that AFD may not condition treatment on my execution of this Authorization.

I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the Recipient listed above and, in that case, will no longer be protected by HIPAA. This authorization expires when I am no longer a patient in this practice or have revoked this authorization. This authorization expires when I am no longer a patient in this practice or have revoked this authorization. (Check One) **I DO____DO NOT____ GIVE PERMISSION** to Armstrong Family Dentistry, PC to leave information on my answering machine and/or with my family members in regard to treatment plans, referrals, test results and/or billing and payment information. HIPAA guidelines allow for basic information regarding appointments (time, date, location) to be left on an answering machine or with family members.

HIPAA regulations authorize the release of PHI for the purpose of treatment, obtaining payment from third party payers, and the day-to-day healthcare operations of AFD. Other than those releases authorized by HIPAA, PHI will only be released to persons listed on this authorization, If you choose not to authorize any family members or friends for disclosure of PHI, AFD will not be able to release any information, including appointment or patient billing questions to anyone other than the patient.

_____ _____

Signature of Patient or Personal Representative (i.e. Guardian) Relationship of Personal Representative to Patient

Date of Authorization_____