Authorization To RELEASE Healthcare Information

Patient's Name:_____ **DOB:**_____

Nicknames or preferred name:_____

I request and authorize Arnette Family Dentistry to RELEASE healthcare information of the patient (name listed above) to the named family member below:

Name:_____ Relation to Patient _____

Address: Street:_____

City:_____ State:_____ Zip code:_____

Cell #:_____ Home #_____

Email:_____

The request and authorization applies to:

Please check all that apply

- ☐ Results of lab tests/x-rays
  - Other_____
- ☐ Financial
- ☐ Medical
- ☐ Appointment reminders/ missed appointments
- ☐ Breach notification

Patient's Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

_____ Date:_____

Signature of Patient or *Personal Representative

***Description of Personal Representative's Authority (attach necessary documentation)**