AUTHORIZATION FOR AMENDMENTS TO HIPAA

Under the HIPAA privacy laws, we cannot give personal dental or financial information to anyone other than the patient (unless the patient is a minor under the age of 18 years); this includes the spouse of the patient or any dependent over the age of 18 years. The following authorizations allow us to provide your dental information to another family member or to leave a message at home, on a cell phone or at work for your convenience.

***Please INITIAL, fill in the required information and SIGN below.

Emergency Only Contact:_____ **Phone#**_____

_____ **I decline having any information regarding my routine dental treatment, finances, appointment times or need for further care released to any individual.**

_____ **I authorize the doctors and/or staff of Hampshire Family Dental to speak with the following persons regarding my dental treatment, finances, appointment times or need for further care via telephone, electronic communications or in person (including reminders for pre-medication if required):**

Name: _____   **Relationship:** _____
Name: _____   **Relationship:** _____
Name: _____   **Relationship:** _____

_____ **I authorize the doctors and/or staff of Hampshire Family Dental to call my home and leave a message on my answering machine about my treatment, need for further care or finances (including reminders for pre-medication if required).**

_____ **I authorize the doctors and/or staff of Hampshire Family Dental to call my cell phone and leave a message regarding my treatment, need for further care or finances (including reminders for pre-medication if required).**

_____ **I authorize the doctors and/or staff of Hampshire Family Dental to call my place of employment regarding my treatment, need for further care or finances and speak to me directly or leave a message. No medical or financial information will be provided in the message.**

This release of information shall be in effect until revoked by me in writing.

_____   _____   _____
Patient (or Legal Guardian) Signature   **Date of Birth**   **Date**

Patient (or Legal Guardian) Printed Name