Pediatric Dental Garden

Authorization for Release of Information to Family Members

Patient Name:_____Date of Birth_____

Many of our patients allow family members such as their parents, grandparents, or others to call / bring their children in for appointments and request medical or billing information. Under the requirements of HIPAA, we are not allowed to give this information to anyone without the parents' consent. If you wish to have your children's medical or billing information released to family members you must sign this form. Signing this form will only give information to family members indicated below.

I authorize Pediatric Dental Garden to release their medical and/or billing information to the following individual(s):

1._____Relation to patient_____

2. _____Relation to Patient_____

3. _____Relation to Patient_____

4. _____Relation to Patient_____

5. _____Relation to Patient_____

I do not wish to allow anyone to receive any 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 disclosure by the above recipient.

You have the right to revoke this consent in writing.

Signature_____ Date_____