KOUP
FAMILY DENTAL

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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Today's Date: _____

Patient Name (please print): _____ Date of Birth: _____

1. By signing my signature below, I hereby authorize the disclosure of my protected health information (including HIV/AIDS related information, if any) to the person(s) listed below.

   Name: _____ Relationship: _____

   Name: _____ Relationship: _____

   Name: _____ Relationship: _____

   Name: _____ Relationship: _____

   Patient Signature: _____ Date: _____

2. By signing below, I hereby authorize the practice to leave my protected health information (including but not limited to results, prescriptions and appointments on my answering machine.

   Patient Signature: _____ Date: _____

3. By signing below, I hereby authorize the practice to mail appointment reminder letters to my home address.

   Patient Signature: _____ Date: _____

***** I received a HIPAA Notice of Privacy Practices. Initials _____ *****

THIS AUTHORIZATION DOES NOT EXPIRE UNLESS OTHERWISE NOTED