Integrity Dental Care, PA

PATIENT COMMUNICATION FORM

Patient Name
(PRINT):_____**DOB:**_____

A. Family and Friends. It is the office policy of this Practice not to release confidential medical and health information regarding your treatment to family members or friends, except for 1) parent/legal guardian; 2) other persons authorized by the patient; 3) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that the person is entitled to receive information regarding your treatment); 4) in emergency situations, or 5) as otherwise permitted by the Health Insurance Portability and Accountability Act (HIPAA).

If you anticipate that you will need or want your medical or health information to be provided to family members, friends, or caretakers/babysitters, please sign below so that we can release that information to that person. If you do not want any of your medical or health information provided to a family member or friend, please circle the "no" response. By signing below, you authorize the following people to receive information regarding your treatment or care. If you wish to add names later on, please confirm this in writing.

You may cancel this authorization to the extent allowed by law. If you do, you understand that the doctor or Practice may have already released information about you after you gave permission. You understand that cancelling this authorization would not prohibit any release of information by the Practice in reliance on your original authorization.

If you wish to cancel or change this agreement, please issue a letter in writing to this Practice.

	Health Care Information	Financial Information
Spouse_____	Yes/No	Yes/No
Parent_____	Yes/No	Yes/No
Other_____	Yes/No	Yes/No
_____	Yes/No	Yes/No

Patient/Parent/Guardian
Signature_____Date: _____
