HOUSTON DENTAL CLINIC

PATIENT NAME_____

AUTHORIZATION TO RELEASE INFORMATION TO FAMILY MEMBERS

Many of our patients allow family members such as their spouse, parents or others to call and request the results of tests and procedures, billing/financial information, appointment date and times. Under the requirements for HIPPA we are not allowed to give this information to anyone without the patient's consent.

If you wish to have your information released to family members such as your spouse, parents or others, you must authorize and sign this form. Signing this form will only give consent to release laboratory and radiology results, billing/financial information, appointment date and times to the members indicated below. This consent form will not allow the Houston Dental Clinic to release any other information to these family members.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize the Houston Dental Clinic to release my laboratory/radiology results and reports, billing/financial information, appointment date and times to the following individuals:

NAME _____

RELATIONSHIP _____

PHONE NUMBER _____

NAME _____

RELATIONSHIP _____

PHONE NUMBER _____

NAME _____

RELATIONSHIP _____

PHONE NUMBER _____

_____ _____

PATIENT (OR PARENT/GUARDIAN) SIGNATURE **DATE**