AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPPA

Patient Name _____ Date of Birth _____

I authorize **Binghamton Dental** to share information regarding my medical care with the Individual(s) and to the degree that I have specified below.

This release covers information concerning medical or dental conditions which may include: mental healthcare, communicable diseases, HIV or AIDS and/or drug and alcohol usage.

I understand that this authorization may be revoked by me at anytime, (revocation must be written to be valid) and that this revocation will be honored with the exception of any requests previously processed. Authorization will automatically expire in the event that I am no longer a patient of the office listed above. The above named office is not legally responsible for any disclosure that may arise from the requested information. The above named office is not authorized to disclose any medical information which was obtained from other providers/offices unless such disclosure is specifically required or permitted by law.

I understand that if I do not want information divulged concerning treatment I must indicate this in writing. If I do not request restriction, I understand that all information can be divulged to the person(s) specified below. **RESTRICTIONS:**

_____

_____

_____

I authorize the following individual(s) (name and relationship)

_____

_____ to:

- ☐ Discuss medical condition/treatment
- ☐ Receive appointment reminder calls
- ☐ Discuss billing/collection issues on my behalf
- ☐ Pick up copies of my medical records
- ☐ Pick up prescriptions
- ☐ Pick up x-ray

Home phone # _____

- ☐ Authorization to leave detailed message
- ☐ Leave call back number only

Work phone # _____

- ☐ Authorization to leave detailed message
- ☐ Leave call back number only

_____ _____

Signature of Parent or Legal Representative Date

_____ _____

Print Name Relationship to Patient