Axiom Dentistry

https://www.axiomdentistry.com/index.php

Authorization for Release of Information for Family Member/Friend

I, _____, DOB: _____, direct Signature Family Dentistry to release my protected health information in the following manner and to the identified persons:

_____	_____	_____
NAME	RELATIONSHIP	PHONE

Health information to be disclosed upon the request of the person named above –
(Check either A or B)

- **A. Disclose** my completed health record (including but not limited to diagnose, lab tests, prognosis, treatment, and billing, for all conditions) OR
- **B. Disclose** my health record, as above, **BUT do not disclose** the following (check as appropriate):
  - Medical/Dental
  - Financial/Billing
  - Other (please specify):
    _____

Form of Disclosure (unless another format is mutually agreed upon between my provider and designee):

- Verbal
- Phone
- Email: _____
- Hard Copy
- Text
- Fax: _____

This authorization shall be effective until (Check one):

- All past, present, and future periods, OR
- Date or event: _____

*In order for email/fax communication to occur, please accept the disclosure below:

☐ For email/fax communication I understand that if email/fax is not sent in an encrypted manner there is a risk it could be accesses inappropriately. I still elect to receive email/fax communication.

Patient Rights:

- I have the right to revoke authorization at any time.
- I may inspect or copy the protected health information to be disclosed and described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

The information is released at the patient's request and this authorization will remain in effect until revoked by the patient.

_____ _____

Signature of Patient or Personal Representative Date

*Description of Personal Representative's Authority (attach necessary documentation)