SOLTERRA DENTISTRY

**Authorization to Release & Discuss Dental Information**

The HIPPA privacy law requires that we are only authorized to communicate with patients themselves, insurance providers and primary care doctors, unless we have authorization in writing by the patient to communicate with others on their behalf. Please provide all family members or friends you want us to be able to speak with. Spouses are not automatically included; their names must be explicitly be stated below.

I understand that my express consent is required to release my health care information. With my signature below, I acknowledge and understand that this information will be kept in my medical record and the above parameters will remain in effect until revoked by me in writing. It is my responsibility to notify my healthcare provider(s) should I wish to change one or more contacts listed below.

**Authorization to Speak with Family/ Friend (including spouses)**

I give the following named person(s) authorization to take messages or speak with the office of Anthem Dentistry PLLC on my behalf regarding (please check all items authorized).

Name of Authorized person: _____ Relationship: _____

Phone Number: _____

Appointments Financial Dental Treatment Insurance Other

Name of Authorized person: _____ Relationship: _____

Phone Number: _____

Appointments Financial Dental Treatment Insurance Other

**I understand that my express consent is required to release any health care information.**

With my signature below, I acknowledge and understand that this information will be kept in my records and remain in effect until revoked by me in writing.

Print Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____