INFORMATION RELEASE AUTHORIZATION

DENTISTRY Of Olde Towne

Kenneth D. Kligman, D.D.S.
Chris Rautenstrauch, D.M.D.
Jacob D. Sluder, D.M.D.

Authorization to Release Information to Family Members

Many of our patients (18 years and older) allow family members such as their spouse, significant other, parents or children to call and request the result of tests, procedures, financial information and scheduling of appointments. **Under the requirements for H.I.P.P.A. we are not allowed to give this information to anyone without the patient's consent.**

If you wish to have your medical information, any diagnostic test result, financial and/or scheduling information released to any family members you **must** sign this form.

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

I authorize Dentistry of Olde Towne to release my records and any information to the following individuals:

Name _____ Relation to Patient_____
Name _____ Relation to Patient_____
Name _____ Relation to Patient_____
Name _____ Relation to Patient_____
Name _____ Relation to Patient_____

Name of Patient (PLEASE PRINT)_____ Date of Birth _____

Patient Signature _____ Date _____