PERMISSION TO SHARE LIMITED HEALTH INFORMATION WITH FAMILY/FRIENDS

Patient Name: ____ DOB: ______/______/_______

By signing this paper below, I give permission to the person(s) to receive limited information about my care. I understand my healthcare provider will use their professional judgment to ensure that information that is shared with my family/friend is in order to assist with my continuing care. Any information requested that does not pertain to assisting with my health care and any requests for copies of medical records will require a signed HIPPA compliant authorization. This permission will be considered ongoing until I state in writing otherwise.

Date of Permission: ______/______/_______

Name of Individual: ____________________________________ Relationship to Patient: ________________

Comments/Instructions: ____
(i.e. pick up prescription, reminder of routine treatment)

Patient/Guardian Initials: _______

THE DENTIST/STAFF HAS MY PERMISSION TO: (Please check all that apply)

___ Leave message at home with my spouse or: NAME: ____

RELATIONSHIP: ___________________ DOB: _______/______/_______

___ Leave message on cell phone.

Cell phone number: __________________________

___ Leave message at work.

Work phone number: _________________________

___ Leave a message on voicemail.

Phone number: _____________________________

___ Leave a detailed message on answering machine:

Phone number: ______________________

___ In order to obtain information by telephone, the party calling the practice must be able to share the patient identifier/password with the staff.

Patient Chosen Identifier/Password: ____

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____ _______/______/_______
Signature of Patient or Legal Guardian Date

____ ______________________
Printed Name of Patient or Legal Guardian Relationship (if not self)

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