Young and Polite Children's Dentistry

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Authorization for Release of Information
To Family and/or Friends

The following form states that Young and Polite Children's Dentistry is authorized to treat my child while I am not present and to release protected health information to the **individual(s) named below**. I understand that the individual bringing my child to the appointment must be at least 18 years of age. I also understand that I am giving consent for this individual to make decisions regarding my child's dental treatment, emergency medical treatment as well as behavior management.

Name of Patient: ______________________________________ Date of Birth: _____________________
Name of Patient: ______________________________________ Date of Birth: _____________________
Name of Patient: ______________________________________ Date of Birth: _____________________
Address: ____
City: ____________________________ State: _________________ Zip Code: __________________

Please list any individuals in which you authorize for the above statement:
Name: __________________________ Relationship to Patient: _________________________
Name: __________________________ Relationship to Patient: _________________________
Name: __________________________ Relationship to Patient: _________________________

Check the information to be released to above named individual:
_______ Financial Information
_______ Results from tests or x-rays
_______ Family Billing Information
_______ Medical information as follows: ____
_______ Other information as described: ____

Rights of the Patient

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by signing a written notification to Young and Polite Children's Dentistry. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that 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 understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing this authorization. This authorization shall be in force and effective until revoked by the patient or representative signing this authorization.

____ Date ____________________________
Signature of Patient or Personal Representative

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