PORTSCHY DENTAL PARTNERS OF MARIETTA

AUTHORIZATION TO RELEASE & DISCUSS DENTAL INFORMATION

The HIPPA privacy law requires that we are only authorized to communicate with patients, guardians, insurance providers and primary care physicians, unless we have the authorization in writing by the patient to communicate with others on their behalf. Please provide all members you want to share your dental information with. **Spouses are not automatically included; their names must be explicitly stated below.** You may opt out by checking the "Do Not Release Information" box below.

AUTHORIZATION TO SHARE MY INFORMATION

I give the following named person(s) authorization to take messages or speak with the office of Portschy Dental Partners of Marietta, on my behalf.

Name of authorized person: ____

Relationship: ____________________________Phone number: ____

_____Appointments _____Financial _____Dental Treatment _____Insurance _____Other (explain) _____________

Name of authorized person: ____

Relationship: ____________________________Phone number: ____

_____Appointments _____Financial _____Dental Treatment _____Insurance _____Other (explain) _____________

AUTHORIZATION TO LEAVE HEALTH INFORMATION BY ALTERNATE MEANS

I authorize Portschy Dental Marietta and staff to use the following telephone numbers provided on the Patient Registration Form to leave messages on voice mail for the reminder calls and other patient matters.

_______________________Home _______________________Work _______________________Cell

________**DO NOT RELEASE INFORMATION TO ANYONE: 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 Dental record and the above parameters will remain in effect until revoked by me in writing. It is my responsibility to notify my health provider(s) should I wish to change any contacts listed above.

Patient Name: ____ Date of Birth: ___________________________

Signature of Patient: ____ Date: ______________________