JOHN G. PORTSCHY, D.D.S., P.C.

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IMPLANTS
COSMETIC DENTISTRY
CROWN & BRIDGE

MINOR ORTHODONTICS
DENTURES
FAMILY DENTISTRY

Authorization to Release & Discuss Dental Information

The HIPPA privacy law requires that we are only authorized to communicate with patients themselves, 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 family members or friends you want us to be able to speak 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 speak with family/friend (including spouse)

I give the following named person(s) authorization to take messages or speak with the office of John G. Portschy, DDS, on my behalf regarding (**please check all items authorized).**

Name of authorized person(s):______________________________Relationship________________

Phone number____

______Appointments____Financial____Dental Treatment____Insurance____Other (explain)______

Name of authorized person(s):______________________________Relationship________________

Phone number____

______Appointments____Financial____Dental Treatment____Insurance____Other (explain)______

Authorization to Leave Health Information by Alternate Means

I authorize John G Portschy, DDS 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 phone

______DO NOT RELEASE INFORMATION TO ANYONE : **I understand that my express consent it 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's Name____________________________________Date of Birth______________________

Signature of patient______________________________________Date_______________________