

## PATIENT AUTHORIZATION FORM

### Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request protected information. Under the requirements for H.I.P.A.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, treatment information and/or financial information released to any family members, you must sign this form.

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

**I authorize Boulevard Smiles to release my records and any information requested to the following individuals.**

1. \_\_\_\_\_ **Relation to Patient:** \_\_\_\_\_

2. \_\_\_\_\_ **Relation to Patient:** \_\_\_\_\_

3. \_\_\_\_\_ **Relation to Patient:** \_\_\_\_\_

4. \_\_\_\_\_ **Relation to Patient:** \_\_\_\_\_

\_\_\_\_\_  
Patient Name (PLEASE PRINT)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature