Authorization to Release Information

Purpose: This form is used for you to authorize MCDC to release your personal health information covered under the Privacy Act to people other than yourself.
The HIPAA privacy law requires that we are only authorized to communicate with patients themselves, guardians, insurance providers, and primary care physicians, unless we have authorization in writing by patients to communicate with others on their behalf. Please provide information for ALL individuals you want us to be able to speak with or provide records to.

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.

Who can information be released to?

Full Name

_____

Relationship

_____

Phone Number

_____

Address

_____

What type of information can be released?

- ☐ Appointments
- ☐ Financial Information
- ☐ Dental Treatment
- ☐ Other: _____

Who can information be released to?

Full Name

_____

Relationship

_____

Phone Number

_____

Address

_____

What type of information can be released?

- ☐ Appointments
- ☐ Financial Information
- ☐ Dental Treatment
- ☐ Other: _____

☐ **DO NOT Release Information**

I hereby authorize the above person(s) to have access to my personal health information covered under the Notice of Privacy Practices. I understand that I may revoke any part or all of this authorization at any time by notifying MCDC.

Patient's First Name _____ Patient's Last Name _____ Patient's Date of Birth _____

Name of Parent or Guardian (if patient is a minor)

_____

Patient/Guardian Signature

Date

_____