



Andresen Prosthodontics

AUTHORIZATION TO RELEASE INFORMATION TO ANOTHER PERSON

Many of our patients allow another person whether it be a family member or another person. This person would have access to your test results, treatment plan or treatment completed and financials. Under the requirements of H.I.P.P.A. we are not allowed to give this information to anyone without the patient's consent. IF you wish to have your medical information and any diagnostic test results and/or financial information released to any person, 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 Andresen Prosthodontics to release my records, and any information requested to the following individuals:

1. _____ Relation to Patient: _____
2. _____ Relation to Patient: _____
3. _____ Relation to Patient: _____

Authorizations regarding messages: (please check all that apply)

I authorize you to leave a detailed message on my home or cell number regarding appointments

I authorize you to leave a detailed message on my home or cell number regarding medical treatment, care, test results or financial information.

I authorize you to leave a message with anyone who answers the phone

Messages may only be left with _____

Patient Name (PLEASE PRINT)

Date

Patient Signature