Texas Pediatric & Stonebridge Ranch Dentistry

Authorization to Disclose Health Information
To Family Members and Friends

Patient Name: _______________________________________ Date of Birth: __ / __ /__

I hereby authorize Texas Pediatric and Stonebridge Ranch Dentistry to release my/ my child's personal health information (PHI) to the following person (s):

Name: ____ Relationship: ____________

Name: ____ Relationship: ____________

Protected Health Information ("PHI") may include information/documents regarding dental/medical treatment of the patient including, but not limited to, diagnosis, procedures, treatment plans, appointments and test results; account and billing information including, but not limited to, account balances, payments and payment arrangements, insurance claims status, and third party financing.

I understand that the Health Insurance Portability and Accountability Act of 1996, and its implementing regulations ("HIPAA") govern the terms of this Authorization. I understand that I have the right to revoke this Authorization, at any time prior to the Practice's compliance with the request set forth herein, provided that the revocation is in writing. I further understand that additional information relating to the exceptions, the right to revoke and a description of how I may revoke this Authorization is set forth in the Practice's Notice of Privacy Practices. I understand that any revocation must include my name, address, telephone number, date of this Authorization and my signature; and that I should send it to the attention of the "HIPAA Compliance Officer".

HIPAA regulations authorize the release of PHI for the purpose of treatment, obtaining payment from third party payers, and the day-to-day healthcare operations of the Practice. Other than those releases authorized by HIPAA, PHI will only be released to the patient, legal parent or guardian, and the persons listed on this authorization.

Signature Patient or Guardian: _____________________________ Date: ____________