**HIPAA AUTHORIZATION FOR RELEASE OF INFORMATION TO FAMILY AND/OR FRIENDS**

**Patient First and Last Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CHERRY CREEK ORAL SURGERY IS AUTHORIZED TO RELEASE PROTECTED HEALTH INFORMATION ABOUT THE ABOVE NAMED PATIENT TO THE FOLLOWING LISTED ENTITIES:**

Entity / Individuals Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Entity / Individuals Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Entity / Individuals Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INITIAL EACH SITUATION GIVING CHERRY CREEK ORAL SURGERY YOUR AUTHORIZATION TO SUPPLY INFORMATION TO YOUR ENTITY:**

\_\_\_\_\_ Text message and e-mail for appointment reminders

\_\_\_\_\_ Text message

\_\_\_\_\_ E mail

\_\_\_\_\_ Leave information on voice mail

\_\_\_\_\_ Give information to grandparent

\_\_\_\_\_ Release financial information

\_\_\_\_\_ Give information to parent (patient is over 18 years of age)

\_\_\_\_\_ Give information to spouse

\_\_\_\_\_ Medical information as follows: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_Other information as described: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RIGHTS OF THE PATIENT: READ AND SIGN BELOW**

I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION AT ANY TIME AND THAT I HAVE THE RIGHT TO INSPECT OR COPY THE PROTECTED HEALTH INFORMATION TO BE DISCLOSED AS DESCRIBED IN THIS DOCUMENT BY SENDING A WRITTEN NOTIFICATION TO KOERICH ORTHODONTICS. I UNDERSTAND THAT A REVOCATION IS NOT EFFECTIVE IN CASES WHERE THE INFORMATION HAS ALREADY BEEN DISCLOSED BUT WILL BE EFFECTIVE GOING FORWARD.

I UNDERSTAND THAT INFORMATION USED OR DISCLOSED AS A RESULT OF THIS AUTHORIZATION MAY BE SUBJECT TO REDISCLOSURE BY THE RECIPIENT AND MAY NO LONGER BE PROTECTED BY FEDERAL OR STATE LAW.

I UNDERSTAND THAT I HAVE THE RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION AND THAT MY TREATMENT WILL NOT BE CONDITIONED ON SIGNING THIS AUTHORIZATION.

THIS AUTHORIZATION SHALL BE IN FORCE AND EFFECT UNTIL REVOKED BY THE PATIENT OR REPRESENTATIVE SIGNING THE AUTHORIZATION.

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**Signature of Patient/Responsible Party/Legal Guardian/Personal Representative Date**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*If not parent/ legal guardian: Description of personal representative’s authority (attach necessary documentation)*