ADVANCED
FAMILY DENTAL CARE

PERMISSION TO SHARE LIMITED HEALTH INFORMATION WITH FAMILY/FRIENDS

Patient Name: _____ DOB: _____/_____/_____

By signing this paper below, I give permission to the person(s) to receive limited information about my care. I understand my healthcare provider will use their professional judgment to ensure that information that is shared with my family/friend is in order to assist with my continuing care. Any information requested that does not pertain to assisting with my health care and any requests for copies of medical records will require a signed HIPPA compliant authorization. This permission will be considered ongoing until I state in writing otherwise.

Date of Permission: _____/_____/_____

Name of Individual: _____ Relationship to Patient: _____

Comments/Instructions: _____
(i.e. pick up prescription, reminder of routine treatment)

Patient/Guardian Initials: _____

THE DENTIST/STAFF HAS MY PERMISSION TO: (Please check all that apply)

___ Leave message at home with my spouse or: NAME: _____

RELATIONSHIP: _____ DOB: _____/_____/_____

___ Leave message on cell phone.

Cell phone number: _____

___ Leave message at work.

Work phone number: _____

___ Leave a message on voicemail.

Phone number: _____

___ Leave a detailed message on answering machine:

Phone number: _____

___ In order to obtain information by telephone, the party calling the practice must be able to share the patient identifier/password with the staff.

Patient Chosen Identifier/Password: _____

_____

_____ _____/_____/_____
Signature of Patient or Legal Guardian Date

_____ _____
Printed Name of Patient or Legal Guardian Relationship (if not self)

REV 8.4.2016