GROOVER FAMILY DENTISTRY

AUTHORIZATION TO RELEASE INFORMATION REGARDING MEDICAL/DENTAL PROTECTED HEALTH INFORMATION FOR FAMILY MEMBERS/ADULT CHILDREN/SPOUSES/CARE GIVERS ECT.

I authorize the use or disclosure of the protected health information ("PHI") as described below. By authorizing the use or disclosure of the PHI described below.

I authorize to allow the persons listed below to have any and all information pertaining to my entire contents of my record, including diagnosis, treatment details and financial information.

Patient's name_____Date_____

I authorize Groover Family Dentistry to release and/or disclose the PHI described above to the following person/people.

Name of person/persons_____

_____

I understand that I have the right to revoke this authorization, in writing, at any time by so notifying the requesting person. Such revocation will not affect actions taken by the requesting person prior to the date he or she received the written notification. I understand information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and will no longer be protected by this rule.

Patient's name_____Date_____