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## HIPPAA-Others Involved In Health Care

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Patient Signature \_\_\_\_\_ Today's Date \_\_\_\_\_

*As a patient would you like to elect to have others involved in your health care? Without your prior approval, we cannot discuss any dental, medical or billing information with family or friends. Please list the names of those you would like listed as being involved in you health care. This information can be changed or revoked with your permission at any time.*

I give permission for information related to my dental, medical and billing information to be discussed with:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

I understand that this might include such information as: diagnosis, prognosis and treatment plans, medications, post op instructions, appointments, billing, insurance and other information relevant to my care.

\_\_\_ I decline to have my medical information discussed with family or friends.