Sue Chadwick Walker DMD, PC

HIPAA – Others Involved In Health Care

Patient's Name_____ Date of Birth_____

Patient Signature_____ Today's Date_____

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

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.