A Winning Smile

ORTHODONTICS

HIPAA Authorization Form for Family Members and Friends

I, ____________________________________, grant permission to Catherine Scheurer McDevitt DMD to disclose and release my protected health information (PHI) to the following persons:

Name (s):	Relationship:
________________________________	________________________________
________________________________	________________________________
________________________________	________________________________

Health Information to be disclosed:

- o My complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions dental and/or medical related)

OR My complete heath record, as above, **with the exception** of the following information: (Check as appropriate):

- o Mental health records
- o Communicable diseases (including HIV and AIDS)
- o All dental records
- o Other (please specify):
  ____

This health information may be used to enable the persons I authorize to know and understand my condition and my treatment or treatment options, for treatment or consultation, for claims payment purposes, or related reasons.

This authorization shall be effective until (check one):

- o All past, present, and future periods,
- o **OR** Until date or event: ______________________________________ unless I revoke it.
  (NOTE: You may revoke this authorization at any time by notifying us in writing.)

____

Printed Name of the Person Giving this Authorization

____ ________________________

Signature of the Person Giving this Authorization Date