Washington Family Dental PLLC
Patient Authorization Form

Authorization to Release Information

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request appointment information or financial information. Under the requirements for HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your information released you must sign this form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Washington Family Dental PLLC to release my records and any information requested to the following individuals:

1. _____ **Relation to Patient:**_____
2. _____ **Relation to Patient:**_____
3. _____ **Relation to Patient:**_____
4. _____ **Relation to Patient:**_____

I authorize Washington Family Dental PLLC to leave detailed messages on my home or cell number regarding appointments and information.

_____

Print Patient Name

_____

Signature Date