PRESTIGE DENTISTRY
COSMETIC & GENERAL DENTISTRY

HIPAA AUTHORIZATION FORM FOR FAMILY MEMBERS/FRIENDS

I, _____, give permission to Prestige Dentistry to disclose and release my protected health information described as below:

Name(s):	Relationship:
_____	_____
_____	_____
_____	_____

Health Information to be disclosed (Check all that apply):

_____ My complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) OR

_____ My complete health record, as above, with the exception of the following information: (check as appropriate):

- _____ Mental Health Records
- _____ Communicable Diseases (including HIV and AIDS)
- _____ Alcohol/drug abuse treatment
- Other (please specify) _____
  _____

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

This authorization shall be effective until (Check one):

_____ All past, present, and future periods, OR

_____ Date or event:_____
unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying Prestige Dentistry)

_____
Name of the Individual Giving this Authorization

_____ _____
Signature of the Individual Giving this Authorization Date