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DISCLOSURE OF INFORMATION TO FAMILY MEMBERS, FRIENDS, CAREGIVERS, OR PERSONAL REPRESENTATIVES

In accordance with the HIPAA (Health Insurance Portability and Accountability Act) guidelines Renée L. I. Owen, DDS, P.C. may disclose your health care information to a family member, relative, close personal friend, or a person you identify as being involved in your health care or the payment of health care. Additionally, information may be disclosed regarding your condition or location to family members, a personal representative, or another person responsible for your care.

HIPAA allows you to object disclosure made to family members, relatives, friends, personal representatives, or caregivers. Every effort will be made to honor your requests unless your healthcare provider determines it is in your best interest to make a disclosure, or Renée L. I. Owen DDS P.C. is legally required to disclose your information.

I understand that I may revoke this authorization at any time by following the directions in the Notice of Privacy Practices. I understand that my revocation must be in writing. This form expires 1 year from date signed.

PLEASE LIST BELOW ANY FAMILY MEMBER, RELATIVE, FRIEND, CAREGIVER, OR A PERSONAL REPRESENTATIVE THAT IS INVOLVED IN YOUR HEALTH CARE OR THE PAYMENT OF HEALTH CARE TO WHO Renée L. I. Owen DDS, P.C. MAY DISCLOSE YOUR INFORMATION IN THE ABSENCE OF THE EXTENUATING CIRCUMSTANCES AS STATED ABOVE.

Name of Patient: _____ DOB: _____ SS#:_____

I authorize the listed person(s) to use or disclose the following health information:

- All of my health information (including treatment, financials, appointments)
- Only my financial information
- Only my appointment information, including changing or scheduling appointments
- Only information in regards to the following treatment or condition:
  _____
- Only information covering the period of (date)_____to (date)_____
- Other as specified:_____
  _____

_____ _____

Name **Relationship to Patient**

_____ _____

Name **Relationship to Patient**

_____ _____

Signature of Patient/Parent/Guardian **Date**