UDA DENTAL
UNIVERSITY DENTAL ASSOCIATES
SCOTT F. TUCKER DDS, MS, PA

AUTHORIZATION FOR RELEASE OF INFORMATION TO FAMILY MEMBERS

Patient Name_____ Account #_____ Date of Birth _____

Many of our UDA patients allow family members such as their spouse, parents or others to call and request dental or billing information. Under the requirements of HIPAA, we are not allowed to give this information to anyone without the patient's written consent. If you wish to have your dental or billing information released to family members/others, you must sign this form. Signing this form will allow UDA to give the individuals listed below your dental and/or billing information.

I,_____ authorize University Dental Associates to release my dental and/or billing
(print patient name or personal representative/relationship)

information to the following individuals:

1. _____ Relation to Patient _____
2. _____ Relation to Patient _____
3. _____ Relation to Patient _____

Patient Information:

I understand I have the right to revoke this authorization at any time and have the right to inspect or copy the protected health information disclosed.

I understand that information disclosed to any above recipient is no longer protected by federal or state law, and may be subject to re-disclosure by the above recipient.

I understand that I have the right to revoke this consent in writing at any time, and am responsible for informing University Dental Associates.

_____ **OR** _____

Patient Signature Date Personal Representative/Relationship Date

****** PLACE THIS SIGNED FORM IN THE PATIENT'S PERMANENT RECORD ******