Felipe Porto, DDS, MS, MSD
enjoyortho.com
616-74-ENJOY
info@enjoyortho.com

Authorization for Release of Information

Patient Name: _____ Date of Birth: _____

Many of our patients/parents allow family members such as spouse, parents, grandparents, relatives or others to request medical/dental or billing information (including discussing the appointment findings and treatment progress). Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's (or a parent's, if patient is a minor) consent. If you wish to have your, or your kid's medical/dental or billing information released to a family member or friend you must sign this form. Signing this form will allow Enjoy Orthodontics to give information only to the person indicated below.

I authorize Enjoy Orthodontics to release my (or my child _____)
( ) Medical/Dental information (including appointment findings and treatment progress)
( ) Billing information

to the following individuals:

1. _____ Relationship: _____

2. _____ Relationship: _____

3. _____ Relationship: _____

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

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subjected to redisclosure by above recipient.

You have the right to revoke this consent in writing at any time.

Signature: _____ Date: _____