# MID-PENN ORAL SURGERY

## AUTHORIZATION TO RELEASE INFORMATION TO FAMILY MEMBERS AND OR FRIENDS

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members or friends you must sign this form. Signing this form will only give consent to release this information to the family members or friends indicated below. This consent will not allow Mid-Penn Oral Surgery, PC to release any other information to these family members.

I authorize/ allow Mid-Penn Oral Surgery, PC to release my medical and/or billing information to the following individual(s):

1. _____ relation to patient: _____
2. _____ relation to patient: _____
3. _____ relation to patient: _____

Patient name: _____

Patient Signature: _____ Date:_____

You do have the right to revoke this in writing.

## AUTHORIZATION TO LEAVE MESSAGES WITH HOUSEHOLD MEMBERS / ANSWERING MACHINE

Occasionally it is necessary for the staff to leave messages for patients. The purpose is to remind patients that they have an appointment, to notify the patient that the medical staff would like to discuss or schedule future appointments, or to ask a patient to call regarding issues or concerns. The purpose of this consent is to leave messages with members of your household or on your answering machine.

Patient name:_____

Patient signature:_____Date:_____

Patient account number:_____

You do have the right to revoke this consent in writing.

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