HIPAA Release and Consent- to someone other than patient

I understand and acknowledge that as of my 18th birthday, my parents and/or guardians will no longer be permitted access to my medical records, information, providers, or appointment status without my specific written permission. Paynesville Family Dental will not speak with my parents, permit my parents to schedule appointments or provide medical information to my parents unless in accordance with this document.

I wish to grant my healthcare providers and/or medical information as follows: (**You must select only ONE option and initial**)
PRINT THE NAME(S) AND INDICATE RELATIONSHIP BELOW OF THOSE WHO MAY ACT ON YOUR BEHALF

- _____
- _____

_____I give the above named individual(s) permission to act on my behalf with no limitations. I understand that they may contact any dentist or member of the staff at Paynesville Family Dental to schedule appointments, discuss my care and access my medical records. **THEY HAVE NO RESTRICTIONS**.

_____I give the above named individual(s) permission to contact and speak with any dentist or member of the staff at Paynesville Family Dental to discuss my care and schedule any needed service or appointments. **I DO NOT GRANT ACCESS TO MY MEDICAL RECORDS**.

_____I give the above named individual(s) permission to contact and speak with any dentist or member of the staff at Paynesville Family Dental for the sole purpose of scheduling an appointment. No access to my medical records or information regarding my care can be discussed or provided. **APPOINTMENT ONLY ACCESS**.

_____I DO NOT GRANT ANY ACCESS TO MY PARENTS OR GUARDIAN. NO MEDICAL INFORMATION, RECORDS OR APPOINTMENT INFORMATION CAN BE RELEASED.

I understand that I can withdraw consent at any time by providing Paynesville Family Dental with a written consent indicating the changes in access.

_____ _____
PATIENT NAME (Print Legibly) PATIENT DOB

(_____) _____ (_____) _____
PATIENT CONTACT # / CELL PHONE ALTERNATE PHONE #

_____ _____
PATIENT SIGNATURE DATE