Smiles of Marshall
303 E Michigan Avenue
Marshall, Michigan 49068
(269) 781-5563

Authorization to Release & Discuss Dental Information

The HIPPA Privacy Law requires that we are only authorized to communicate with patients themselves, guardians, insurance providers, and primary care physicians, unless we have authorization in writing by the patient to communicate with others on their behalf. Please provide all family members or friends you would like us to be able to speak with. **Spouses are not automatically Included; their names must be explicitly stated below.** You may opt out by checking the "DO NOT RELEASE INFORMATION" box below.

Authorization to speak with famlly frlend including spouse)

I give the following named person(s) authorization to take messages or speak with the office of Smiles of Marshall Dentistry, LLC, on my behalf:

Name of authorized person(s): _____
Relationship:_____Phone Number:_____

Name of authorized person(s): _____
Relationship:_____Phone Number:_____

Name of authorized person(s): _____
Relationship:_____Phone Number:_____

Authorization to Leave Health Information by Alternate Means

I authorize Smiles of Marshall Dentistry, LLC and staff to use the following telephone numbers provided on the Patient Registration Form to leave messages on voicemail for reminder calls and other patient matters.
_ Home Phone _Work Phone _ Cell Phone/ Text Message _ Email

☐ DO NOT RELEASE MY INFORMATION TO ANYONE

I **understand that my express consent is required to release any health care Information.** With my signature below, I acknowledge and understand that this information will be kept in my medical record and the above parameters will remain in effect until revoked by me in writing. It is my responsibility to notify my healthcare provider(s) should I wish to change one or more contacts listed above.

Patient's Name: _____ Date of Birth: _____
Please Print Name

_____ _____
Signature of patient or patient's authorized representative Date