

## 18 & Over - HIPAA Release and Consent Form

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.

Butte Family Dental will not speak with my parents about my appointments, or release medical information to my parents without my written consent in accordance with this document.

This Authorization will be valid until otherwise noted in writing from the patient.

**I DO NOT** grant any access to my parents and/or guardians. **No medical information, records or appointment information can be discussed or released.**

For the purpose of helping me with my healthcare,

**I WISH TO** grant my parents and/or guardian access to my healthcare providers and/or dental information as follows:

I give the below-named individual(s) permission to act on my behalf. I understand that they may contact any dentist or member of the staff at Butte Family Dental to schedule appointments, discuss my healthcare, and access my medical records.

**I understand that:**

1. The purpose of this document is to allow me to make a decision as to whether to allow the release of my personal information.
2. I do not have to sign this authorization in order to receive treatment.
3. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule or other law protecting its confidentiality.
4. I have the right to revoke this authorization in writing, except where the office has acted in reliance upon it. My written revocation must be submitted to: *Privacy Officer, Butte Family Dental 820 Sampson St. Butte, MT 59701*
6. This form may be deemed INVALID if all sections are not completed.

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PATIENT SIGNATURE

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PATIENT PRINTED NAME

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DATE OF BIRTH

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PATIENT CELL PHONE

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DATE

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HIPPA RELEASED TO ABOVE PARENTS/GUARDIANS