Northwoods Dentistry, S.C.

605 Peterson Drive	244 Division Street	720 Garfield Avenue	915 Casement Court
Phillips, WI 54555	Park Falls, WI 54552	Ladysmith, WI 54848	Medford, WI 54451
715-339-3021	715-762-2188	715-532-7054	715-748-2688

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 want 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 family/friend (including spouse)

I give the following named person(s) authorization to take messages or speak with the office of Northwoods Dentistry, S.C. , on my behalf regarding (**please check all items authorized)**.

Name of authorized person(s):_____Relationship_____
___Appointments ___Financial ___Dental Treatment ___Insurance ___Other (explain)

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___Appointments ___Financial ___Dental Treatment ___Insurance ___Other (explain)

Authorization to Leave Health Information by Alternate Means

I authorize Northwoods Dentistry, S.C. and staff to use the following telephone numbers provided on the Patient Registration Form to leave messages on voice mail for reminder calls and other patient matters.
___Home Phone ___Work Phone ___Cell Phone ___E-mail

___DO NOT RELEASE 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