East Dental Family Dentistry

Patient Advocate Form

A. Family and Friends. It is the office policy of this Practice not to release the confidential medical and health information regarding your treatment to family members or friends, except for 1) parent/legal guardian; 2) other persons authorized by the patient; 3) people we may reasonably infer from the circumstances (for example, if you bring a family member or friends into the exam room, we will assume unless you object, that the person is entitled to receive information regarding your treatment); 4) in emergency situations, or 5) as otherwise permitted by the Health Insurance Portability and Accountability Act (HIPPA).

If you anticipate that you will need or want your medical or health information to be provided to family members, friends, or caretakers/babysitters, please sign below so that we can release that information to that person. If you do not want any of your medical or health information provided to a family member or friend, please circle the "no" response. By signing below, you authorize the following people to receive information regarding your treatment or care, including potential voice and text messages. If you wish to add names later on, please confirm this in writing.

You may cancel this authorization to the extent allowed by law. If you do, you understand that the doctor or Practice may have already released information about you after you gave permission. You understand that canceling this authorization would not prohibit any release of information by the Practice in reliance on your original authorization. If you wish to cancel or change this agreement, please issue a letter in writing to the Practice.

	Health Care Information	**Financial Information**
Patient Advocate ____________________	Yes / No	Yes / No
Patient Advocate ____________________	Yes / No	Yes / No
Patient Advocate ____________________	Yes / No	Yes / No

If you wish to decline listing an advocate please initial here_________

*Declining a patient advocate indicates there is no other person who may call on your behalf to discuss health or financial information (Emergency contact excluded) *

B. Alternative Communications. You are entitled to specify alternative, reasonable means of communication, if you do not want to be contacted in a certain way, please let us know.

Printed Name:____Date____________________

Signature (Patient/Parent/Guardian)____

Office Use Only : ____