

Prosper Smiles Family Dentistry

Vimal A. Patel, DDS
821 N. Coleman St. Suite 120
Prosper, Texas 75078
Ph: 972-347-9617

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 Vimal A. Patel, DDS, on my behalf regarding **(please check all items authorized)**.

Name of authorized person(s): _____ Relationship _____

Phone number _____

Appointments Financial Dental Treatment Insurance Other (explain) _____

Name of authorized person(s): _____ Relationship _____

Phone number _____

Appointments Financial Dental Treatment Insurance Other (explain) _____

Name of authorized person(s): _____ Relationship _____

Phone number _____

Appointments Financial Dental Treatment Insurance Other (explain) _____

Authorization to Leave Health Information by Alternate Means

I authorize Vimal A. Patel, DDS 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

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