



**HIPAA Authorization for Disclosure to Family Members**

**Patient Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**I authorize Carabelli Dental to share my health information with the following person(s):**

**Name of individual:** \_\_\_\_\_

**DOB:** \_\_\_\_\_

**Relationship:** \_\_\_\_\_

**Information that can be shared:**

- Appointments
- Medical or treatment info
- Billing/insurance info
- Other: \_\_\_\_\_

**Purpose of sharing:** \_\_\_\_\_

**I understand:**

- I can revoke this permission at any time in writing.
- Information shared may be re-disclosed by the person I authorize.

**Expiration:** \_\_\_\_\_

**Patient / Legal Representative Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Relationship to Patient (if not self):** \_\_\_\_\_