MYSTIC DENTAL GROUP
A PROFESSIONAL CORPORATION

AUTHORIZATION TO RELEASE INFORMATION TO FAMILY MEMBER

Many of our patients allow family members such as their spouse, parents, or others to call and discuss dental treatment, medical, insurance, or billing information. Under the requirements of HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your dental treatment, medical, insurance, or billing information released to family members, you must sign this form. Signing this form will only give consent to release this information to the family members listed below. This consent form will not allow **Mystic Dental Group** to release any other information to these family members.

You have the right to revoke this consent in writing.

I authorize/allow Mystic Dental Group to release my dental treatment or billing information to the following person(s).

1. _____ Relationship to Patient _____

2. _____ Relationship to Patient _____

3. _____ Relationship to Patient _____

AUTHORIZATION TO LEAVE MESSAGE WITH HOUSEHOLD MEMBERS ON VOICE MAIL, ON CELL PHONE:

Occasionally it is necessary for the staff of Mystic Dental Group to leave messages for patients. The purpose of these messages is to notify the patient that the staff would like to discuss or schedule your treatment or to ask a patient to call regarding as issue or concern. The purpose of this consent is to leave a message with members of your households, on your voice mail, or your cell phones.

****This practice performs automated call, email, and test appointment reminders. The signature below also provides your consent for such reminders.**

You have the right to revoke this consent in writing.

Patient Name/Print: _____

Patient Signature: _____

Date: _____