Amanda N. Siu, D.D.S.
Board Certified Pediatric Dentist

AUTHORIZATION TO RELEASE INFORMATION TO FAMILY MEMBERS

Due to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) we are no longer allowed to release patient information to anyone other than the patient or legal guardian, unless specific written authorization is given to our office. In the space below, list any family members that you give your permission for the Doctor or dental team member to discuss your/your child's (if a minor) medical information. This permission can be rescinded at any time per the patient's verbal or written request. This authorization is to facilitate continuity of care and you are entitled to receive a copy of this agreement.

Family Member / Personal Representative	Relationship
____	____________________________
____	____________________________
____	____________________________

I authorize (check one)
o All Medical information, including but not limited to records pertaining to examinations, treatments, consultations, billing records, x-rays and reports, history, laboratory findings, admissions and discharge reports, treatment records, diagnosis and prognosis and records, nurse's and doctor's notes and any other non-medical information in my file.
o Only the following types of Information: ___________________________________

For minors, child(ren) covered by this release: ____
Patient / Guardian Printed Name: ____
Patient / Guardian Signature: ____
Date: ________________

Authorization to Identify Self with Messages (Authorization to leave messages on recorder)

My signature below authorizes Dr. Siu and/or staff to identify themselves from the doctor's office when calling to leave a message regarding my / my child's appointments, results, referrals, or other medical information on any answering device or with another person answering the phone. I also authorize Amanda N. Siu, D.D.S. Inc. to use Text and E-mail programs to communicate with me regarding my / my child's appointment.

Preferred method of contact: o Phone: ________________ o Text: ______________ o Email: ________________
For minors, child(ren) covered by this release: ____
Patient / Guardian Printed Name: ____
Patient / Guardian Signature: ____
Date: ________________