Over 18 HIPAA Release and Authorization Form

I understand and acknowledge that as of my 18th birthday, my parents and/or guardians will no longer be permitted access to my dental records, information, providers, or inquire about appointment status without my specific written permission. Dental Care 4 Kids will not release dental information to my parents without my written authorization in accordance with this document.

____ **I DO NOT** grant any access to my parents and/or guardians**. No dental information, records or appointment status information can be discussed or released.**

_____ **I WISH TO** grant my parents and/or guardian access to my dental care providers and/or dental information as follows:

_____
(Print Name of the parent or guardian; indicate his/her relationship to you.)

_____
(Print Name of second parent or guardian; indicate his/her relationship to you.)

_____ I give the above-named individual(s) permission to act on my behalf with no limitations. I understand that they may contact any provider or staff member to discuss my dental care, and access my complete dental records and they may receive contact by phone, email, mail and any other means for appointment communication. **THEY HAVE NO RESTRICTIONS. (Initials)**

_____ _____
PATIENT PRINTED NAME DOB

_____ _____ _____
PATIENT CONTACT NUMBER DATE PATIENT CONTACT NUMBER

I acknowledge that I have received the Notice of Privacy Practices _____. (Initials)

This authorization is valid indefinitely from the date signed unless Dental Care 4 Kids is notified otherwise. I understand that I can withdraw consent at any time by providing Dental Care 4 Kids with written notice indicating the changes in access. I understand that authorizing this disclosure of this dental information is voluntary. I need not sign this form to assure dental care or treatment. I understand that once the above information is disclosed it may be re-disclosed by the recipient and may no longer be protected by federal or state privacy regulations.