School of Orthodontics
BROOKS REHABILITATION
COLLEGE OF HEALTHCARE SCIENCES

PERMISSION TO COMMUNICATE WITH FAMILY MEMBERS AND/OR OTHERS

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), health care providers are prohibited from releasing or discussing any personal health information to anyone without appropriate permission. Therefore, we need your written authorization if you would like us to communicate with anyone other than the patient or the child's legal guardian(s). Please let us know with whom we may communicate regarding any aspects of the orthodontic care.

Patient Name_____ **Patient DOB:** _____ **Date:** _____

I, _____, authorize Brooks Rehabilitation College of Healthcare Sciences, School of Orthodontics to release or discuss

☐ Health information for the above named patient

☐ Financial/Insurance information regarding the above named patient

To the following people:

Name:_____ Phone #:_____

Relationship to Patient: _____

Permission to give consent to treatment: ☐ Yes ☐ No

Name:_____ Phone #:_____

Relationship to Patient: _____

Permission to give consent to treatment: ☐ Yes ☐ No

Name:_____ Phone #:_____

Relationship to Patient: _____

Permission to give consent to treatment: ☐ Yes ☐ No

_____ _____

Signature of Patient or Parent/Guardian Print Name

Patient ID: _____