LIGHTSHIP DENTAL, INC.

HIPAA Patient Consent Form

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, parents or others to call and request the results of tests and procedures, billing/financial information, appointment date and times. Under the requirements for HIPAA we are not allowed to give this information to anyone without the patient's consent.

If you wish to have your information released to family members, you must authorize and sign this form. Signing this form will only give consent to release laboratory and radiology results, billing/financial information, appointment date and times to the family members indicated below. This consent form will not allow Lightship Dental to release any other information to these family members.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Lightship Dental to release my laboratory/radiology results and reports, billing/financial information, appointment date and times to the following individuals:

1._____

Relation to Patient_____

Date_____

2._____

Relation to Patient_____

Date_____

_____Authorize _____Not Authorized

PATIENT NAME: _____