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HIPAA Consent to Disclose Your Health Care Information to Family Members, Friends, and Others Involved in Your Care:

At your request, we may disclose your health information to a family member or other person if necessary to assist with your treatment and/or payment for services. Based on our judgement and as per 164.522(a) of HIPAA we may disclose your information to these persons in the event of an emergency situation. We also may make information available so that another person may pick up filled prescriptions, medical or dental supplies, records, or x-rays for you. Your information may be disclosed to assist in notifying a family member, caregiver, or personal representative of your location, condition, or death.

This information will only be disclosed to the persons you name below. By your signature below, you give permission to Dr. C. Scott Schmitt, Dr. Alvaro Ramos, and/or any representatives of Schmitt Prosthodontics to discuss information, based on our judgement, that is pertinent to your care.

PATIENT'S SIGNATURE: _____ **DATE:** _____

I, _____, give my permission to C. Scott Schmitt, DMD, MS, PA and/or representatives of Schmitt Prosthodontics to discuss my healthcare information with the following persons:

NAME: _____ **RELATIONSHIP:** _____

NAME: _____ **RELATIONSHIP:** _____

NAME: _____ **RELATIONSHIP:** _____

NAME: _____ **RELATIONSHIP:** _____

NAME: _____ **RELATIONSHIP:** _____