Personal Representation Authorization for Medical / Dental Release Form

I authorize Farrokh Bashiri, DDS INC and staff to speak to the following family members or my personal representative regarding:

_____All medical information, including but not limited to records pertaining to examinations, treatments, consultations, billing records, radiographs and reports, laboratory findings, admissions and discharge reports, treatment records, diagnosis and prognosis, staff and doctor's notes and any other non-medical/dental information in my file.

☐ Only the following type of information: (please indicate)

_____

_____

The above medical/dental information shall only be released to the following persons (s).

Family Member/Person/Representative	Relationship
_____	_____
_____	_____

I understand that I may terminate this medical/dental authorization form. I must notify the office of Dr. Farrokh Bashiri, DDS in writing regarding termination and effective date.

This authorization shall remain valid (check one)

_____Until revoked in writing

_____Until year 20__

I know that I am entitled to receive a copy of this agreement.

Patient's name:_____ Patient's signature_____ Date_____

Personal Rep's name:_____ Personal Rep's Signature:_____ Date_____

_____

HIPPAA Compliance Services:

Revocation: This authorization is also subject to written revocation by the member/patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.

Disclosure: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

Authorized Representative of Patient	Relationship to patient	Witness:
Signed/Date_____	_____	_____

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