# Michael Morris, DDS

**9318 Louetta, Ste 600**
**Spring, Texas 77379**

## AUTHORIZATION TO RELEASE & DISCUSS DENTAL INFORMATION

The HIPAA privacy law requires that we are only authorized to communicate with patients themselves, guardians, insurance provider, and primary care doctor, unless we have authorization in writing by the patient to communicate with others on their behalf. Please provide all family members or friends you want us to be able to speak with. **Spouses are not automatically included; the names must be explicity stated below.**

**Authorization to speak with family/friend (including spouse)**

I give the following person(s) authorization to take messages or speak with the office of Michael J Morris, DDS, PLLC on my behalf.

Name of authorized person(s): ________________________ Relationship: ____________

Phone: ________________________

Name of authorized person(s): ________________________ Relationship: ____________

Phone: ________________________

Name of authorized person(s): ________________________ Relationship: ____________

Phone: ________________________

**Authorization to Leave Health Information by Alternate Means**

Michael J Morris, DDS, PLLC, will use any and all numbers provided by patient on the Patient Registration Form to leave messages on voice mail for reminder call and other patient matters.

☐ I have read

☐ **DO NOT RELEASE INFORMATION TO ANYONE**

With my signature, I acknowledge and understand that this information will be kept in my dental record and the above information will remain in effect until revoked by me in writing. It is my responsibility to notify my healthcare provider(s) should I wish to change one or more contacts listed above.

________________________________________
Patient's Name

________________________________________ ____________________
Signature of Patient or Patient's Authorized Representative Date