University Dental Associates HIPAA Authorization Form for Family Members and Friends

I, ____________________________________, give permission to University Dental Associates to disclose and release my protected heath information described below to:

Name(s):	Relationship:
_________________________________	_______________________________
_________________________________	_______________________________
_________________________________	_______________________________
_________________________________	_______________________________
_________________________________	_______________________________

This health information may be used to enable the person I authorize to know and understand my condition and my treatment or treatment options, for treatment or consultation, for claims payment purposes or related reasons.

This authorization shall be effective until (check one):

- All past, present, and future periods
- Date or event: ____ unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care provider in writing)

____ ______________

Signature of the Individual Giving this Authorization Date

University of Nebraska Medical Center

College of Dentistry, University Dental Associates

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