18–26 year old Patient Communication Authorization

SECTION 1: Patient Information

- Patient Full Name
- Date of Birth
- Phone Number
- Email Address

SECTION 2: Important Privacy Information

If you are age 18 or older, you are legally an adult. Even if you are covered under a parent or guardian's insurance policy, federal privacy laws (HIPAA) require your written authorization before we can discuss your care, appointments, or billing information with anyone else.

You may choose to:

• Allow communication with a parent/guardian

• Allow limited communication

• Decline all communication

Your decision will not affect your treatment.

SECTION 3: Parent / Guardian Information (Required if you authorize us to share your information with your parents)

Parent/Guardian Name: _____

Relationship to Patient: _____

Phone Number: _____

Email Address: _____

SECTION 4: Authorization Options

REQUIRED. Check 1 box.

☐ Full Authorization

I authorize Des Moines Family Dentistry to discuss all aspects of my dental care, treatment, appointments, insurance, and billing with the person listed above.

☐ Limited Authorization

I authorize Des Moines Family Dentistry to discuss ONLY the following (select below):

☐ Appointment scheduling only

☐ Billing and insurance information only

☐ Treatment recommendations only

☐ Emergencies only

☐ No Authorization

I do NOT authorize Des Moines Family Dentistry to discuss my care with any parent, guardian, or other person.

SECTION 5: Substance Use Disorder (SUD) Protection

If your dental record includes information related to Substance Use Disorder (SUD) diagnosis, referral, or treatment, that information is protected under federal law (42 CFR Part 2).

Even if you select Full Authorization above, please select one of the following:

☐ I specifically authorize disclosure of any applicable SUD-related information to the person listed above.

☐ I do NOT authorize disclosure of SUD-related information.

SECTION 6: Duration of Authorization

This authorization will remain in effect:

☐ One year from today

☐ Until revoked in writing

☐ Until this date: _____

SECTION 7: Revocation Statement

I understand that:

• I may revoke this authorization at any time in writing.

• Revocation does not apply to information already disclosed.

• If I select “No Authorization,” my parent/guardian may still be financially responsible but will not have access to my protected health information without my written consent.

SECTION 8: Digital Signature

REQUIRED:

Patient Signature