KATHRYN HORUTZ DMD
FAMILY DENTISTRY

18 and Over- HIPAA Release and Consent Form

I understand and acknowledge that as of my 18th birthday, my parents, and/or guardians will no longer be permitted access to my medical records, information, providers, or appointment status without my specific written permission. Additionally, we will not speak to your parents, permit your parents to schedule appointments or release information to your parents without your written consent in accordance with this document.

This authorization will be valid though 21 years of age, or on the following date _____.

_____ **I DO NOT** grant any access to my parents and/or guardian. ***NO INFORMATION, RECORDS OR APPOINTMENT INFORMATION CAN BE DISCUSSED OR RELEASED.***

_____ **I WISH TO** grant my parents and/or guardians access to my dental healthcare providers and /or information.

Patient Signature _____ Date_____

Patient Printed Name _____

Patient Date of Birth _____

Patient cell phone _____

Patient email _____