Patient's Full Legal Name ____

Birth Date ______________________ Record No. _____________ (for Office Use Only)

Family Members and Friends Involved In Discussing Patient Care

This form documents my request to allow family members and/or friends to be involved in verbal discussions regarding my health care. The people listed below may receive any verbal information needed to participate in my care or to help me make decisions. By signing this form, I permit staff within the University of Michigan School of Dentistry to discuss information about me with the people listed below. This information may include diagnoses, test results, treatment options and other information from previous School of Dentistry services.

- I understand that signing this form is voluntary and that information may be released to family members or others without this form, if allowed by federal and state law.*
- I understand that listing a person on this form does not give them the right to receive or copy my written medical records. Refer to Authorization to Release Patient Information (www.dent.umich.edu/)
- I understand that listing a person on this form does not allow them to consent for health care services on my behalf. Documentation of Guardianship or Medical Durable Power of Attorney must be provided by the patient and/or designee.

NAME	PHONE	ADDRESS	RELATIONSHIP TO PATIENT

The following information has special protection under Michigan law and will be made available to the people I've listed above only if I indicate my approval by checking the box(es) below and initialing the line(s).

________ ❑ HIV/AIDS or other communicable diseases including sexually transmitted diseases, venereal disease, tuberculosis, and hepatitis

________ ❑ Substance abuse services

________ ❑ Mental health services

I can update this form at any time by completing a new form and either giving it to my provider or forwarding it to:
University of Michigan School of Dentistry, Central Records, 1011 N. University, Ann Arbor, MI 48109-1078
Phone 734-764-6152 or Fax 734-615-7040.

Expiration Date: ________________________________
I can revoke or cancel this form at any time by sending written notification to the same address (or fax).

This form does not give the people listed above the right to directly access my dental information by using any Information Technology System (like axiUm, CareWeb or other Electronic Health Records) within the University of Michigan.

Signature: ____ Date: ____________________
(Print Name) ____

* Refer to our Notice of Privacy Practices at: http://www.uofmhealth.org/Patient+and+Visitor+Guide/hipaa