# Boiling Springs Family Dentistry
# David R. Hendrick DDS, PA
## Authorization for Release of Information to Family and /or Friends

Patient: ______________________________ DOB _______________________

**Boiling Springs Family Dentistry** is authorized to release protected health information about the above named patient to the entities below.
**Entity to receive Information. Initial each that is subject to this authorization.**

**___Give information to spouse**
**___ Give information to the following persons:**

___________________________________________

**Description of Information to be released:**
_____ Financial Information _____Medical/Treatment Information
_____ Family Billing Information

**PREFERED METHOD OF CONTACT:**
**Email:____ Email address: __________________**
**Text: _____ Cell phone/s : ________________________________**
**Answering Machine: _____ Land Line : ________________________**

**Persons Authorized to bring minor children for treatment in our office:**

_____________________________________________________________________________________

**Rights of the Patient**
I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to **Boiling Springs Family Dentistry.**
I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditional on signing this authorization.
This authorization shall be in force and effect until revoked by the patient or representative signing the authorization.

______________________________________________ Date: ___________________
Signature of Patient or Personal Representative

Description of Personal Representative's Authority (attach necessary documentation)