2752 Pleasant Road, Suite 106, Fort Mill, SC 29708

Patient Name:	**Date of Birth:**

AUTHORIZATION FOR RELEASE OF INFORMATION TO FAMILY MEMBERS

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPPA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members you must complete and sign this form. Signing this form will only give information to family members indicated below.

I authorize Jasper Dentistry to release my medical and/or billing information to the following:

1. Name: _____ Relationship to Patient: _____

2. Name: _____ Relationship to Patient: _____

3. Name: _____ Relationship to Patient: _____

4. Name: _____ Relationship to Patient: _____

Patient Information

I understand 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.

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to re-disclosure by the above recipient.

I understand I have the right to revoke this consent in writing.

Signature:	**Date:**

NOTICE OF PRIVACY PRACTICES

By **signing** this **form**, I _____ acknowledge that I have received the **Notice of Privacy Practices**. This **Notice** describes in detail how we might use or disclose your protected health information. Also discusses your rights and our duties with respect to your protected health information.

Signature: _____ **Date**: _____