

Authorization for Release of Information to Family Members

Many of our patients allow family members (spouse, parents, children) to call and request dental and/or billing information. Under requirements of HIPPA, we are not allowed to give information to anyone with out the patient's consent.

If you wish to have your dental and/or billing information released to family members, you must sign this form. Signing this form will only give information to family members indicated below.

I authorize **Michigan Endodontics, P.C. Blue Water Endodontics** to release my dental and/or billing information to the following individual(s):

1. _____ Relationship: _____

2. _____ Relationship: _____

3. _____ Relationship: _____

I understand that I have a right to revoke and/or change this authorization at any time. I understand that I must provide written documentation to do so.

Patient name: _____ Date: _____

Signature: _____