SOUTHERN DENTAL ASSOCIATES, PA
151 W. Airport Blvd.
Pensacola, FL 32505

AUTHORIZATION TO RELEASE INFORMATION TO FAMILY MEMBERS or OTHER INDIVIDUALS:

Many of our patients allow family members such as their spouse, parents or others to call and request dental, medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your dental, medical or billing information released to family members or other individuals you must sign this form. Signing this form will only give consent to release this information to the family members or other individuals indicated below. This consent form will not allow Southern Dental Associates, P.A. to release any other information to these family members or other individuals. You have the right to revoke this consent in writing.

I authorize/allow Southern Dental Associates, P.A. to release my dental, medical and/or billing information to the following individual(s):

1: _____ Relation to patient: _____

2: _____ Relation to patient: _____

3: _____ Relation to patient: _____

Patient name: _____

Patient signature: _____ Date: _____