Edisto Dental Associates, LLC

Patient Authorization for Release of Protected Health/Dental Information to Another Person

(Spouse, Friend, Family)

By signing I authorize Edisto Dental Associates to release verbal information, or copies of protected health/dental information about me to:

List Person(s) Below:

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This authorization permits Edisto Dental Associates to release the following individually identifiable health/dental information about me such as the following: (Medical Notes, Labs, or Any Accounting Information to the Person(s) Above).

The information will be used or disclosed for the following purpose: For Continued Medical Release of the information.

The purpose(s) is/are provided so that I can make an informed decision on whether to allow release of the information.

My Patient Rights Are:

I do not have to sign this authorization in order to receive treatment from Edisto Dental Associates. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to disclosure by the recipient and may no longer be protected by the HIPPA Privacy Law. I have the right to revoke this authorization in writing except to the extent that the submitted to the privacy officer.

Signed by: ______________________________ ______________________________

SIGNATURE OF PATIENT OR LEGAL GUARDIAN RELATIONSHIP TO PATIENT