Authorization to Discuss my Health and Dental Information

Bow Family Dentistry, PLLC
514 South Street
Bow, NH 03304
603-224-3151

PATIENT NAME:_____ **DATE OF BIRTH:**_____

PARENT OR LEGAL GUARDIAN:_____

- ☐ If I am not present, I authorize Bow Family Dentistry providers and staff to discuss my relevant health and dental information with the family members and/or friends named below.
- ☐ If I am not present, I authorize Bow Family Dentistry providers and staff to discuss my insurance and billing information with the family members and/or friends named below.
- ☐ I decline to name family members and/or friends who my providers and staff may discuss my health information with at this time. However, I understand that I can always verbally authorize providers and staff to discuss health information with family members and/or friends or I may complete this form at a later date.

For a complete description of how your health information may be used and disclosed, you may request a copy of our *Notice of Privacy Practices*.

Name:_____ Relationship:_____ Phone #:_____

Name: _____ Relationship:_____ Phone #:_____

Name:_____ Relationship:_____ Phone #:_____

Name: _____ Relationship:_____ Phone #:_____

I understand that this authorization is valid and in effect until such time as I withdraw it in writing.

I understand that I can revoke, update, or change this verbal authorization at any time in writing. The termination to verbally release health and medical information is effective on the date the physician office receives it. It does not apply to any information released prior to the date of receipt of the written termination.

_____

Patient Name (Type or Print) Date _____

_____

Signature