H. Nelson Eddy, DDS, P.A.

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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

With our permission, we may disclose your Protected Health Information to a family member, relative, close friend or any other person you identify that is directly involved in your health care.

I, _____, authorize H. Nelson Eddy, DDS, P.A. to release any personal information relating to my health care.

To: _____ Relationship to Patient: _____
To: _____ Relationship to Patient: _____

I understand I have the right to restrict information that may be released and that this restriction must be in writing.

_____ No Restrictions

_____ With Restrictions: (Please list): _____
_____

Name (printed): _____ Date: _____

Signature: _____