MARKET COMMON DENTISTRY

James E. Mills, DDS & Associates
1342 Farrow Parkway, Myrtle Beach, SC 29577
843-293-6700

Authorization to Release & Discuss Dental Information

The HIPAA privacy law requires that we are only authorized to communicate with patients themselves, guardians, insurance provider and primary care doctor, unless we have authorization in writing by the patient to communicate with others on their behalf. Please provide all family members or friends you want us to be able to speak with. **Spouses are not automatically included**; **their names must be explicitly stated below**. You may opt out by checking the "Do not Release Information" box below.

Authorization to speak with family/friend (including spouse)

I give the following named person(s) authorization to take messages or speak with the office of MARKET COMMON DENTISTRY, PC on my behalf regarding (**please check all items authorized**).

Name of authorized person(s): ______________________________ Relationship ____________________
Phone number ____________________

☐ Appointments ☐ Financial ☐ Dental Treatment ☐ Insurance ☐ Other (explain) ________________

Name of authorized person(s): ______________________________ Relationship ____________________
Phone number ____________________

☐ Appointments ☐ Financial ☐ Dental Treatment ☐ Insurance ☐ Other (explain) ________________

Name of authorized person(s): ______________________________ Relationship ____________________
Phone number ____________________

☐ Appointments ☐ Financial ☐ Dental Treatment ☐ Insurance ☐ Other (explain) ________________

Authorization to Leave Health Information by Alternate Means

JAMES E. MILLS, DDS, PC will use any and all numbers provided by patient on the Patient Registration Form to leave messages on voice mail for reminder calls and other patient matters.

☐ I have read

☐ DO NOT RELEASE INFORMATION TO ANYONE

I understand that my express consent is required to release any health care information.

With my signature below, I acknowledge and understand that this information will be kept in my medical record and the above parameters will remain in effect until revoked by me in writing. It is my responsibility to notify my healthcare provider(s) should I wish to change one or more contacts listed above.

Patient's Name: ______________________________________ Date of Birth _____________________
Please Print Name

____ _________________________________
Signature of patient or patient's authorized representative Date