Joseph R. Hendrick, Jr., DDS, PA 511 North Morgan Street, Shelby, NC 28150 * Phone 704-484-0077*

Authorization for Release of Information

Dr. Joseph R. Hendrick, Jr is authorized to release health and financial information about the above named patient to the individuals named below. The purpose of this form is to release information only to those indicated, and only release the minimum necessary information unless otherwise instructed to do so by the patient. Medical and financial information will not be sent via email or text messages. Please indicate the person and type of information to be released. I understand that I may revoke this release at any time by notifying the office in writing. This authorization is in affect until written suspension.
I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

I authorize the release of medical and financial information to the following named persons:

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

_____ I do/ do not authorize information to be left on voice mail or answering machine.

_____ I do/ do not authorize the staff to call my place of employment.

_____ I authorize the staff to contact me via email with appointment reminders.
My email address is: _____
_____ I authorize the staff to contact me via text message for appointment reminders.
My cell number is: _____

_____I would like to be excluded from any practice communication on new procedures/products and any marketing information.

Signature of Patient _____ Date _____

Signature of Parent _____ Date _____
(If patient is a minor)

Revised 5/6/2013