WOODSPRINGS
Family Dentistry
DR. SARAH PHILLIPS YARNELL, DDS

Patient Name: _____

Date of Birth: _____

Woodsprings Family Dentistry is authorized to release my private protected health information and account information to the following individuals.

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

Any time any of these individuals contact Woodsprings Family Dentistry regarding your health account information, they will be asked to identify himself/herself and could be asked your social security number. Please make sure they are knowledgeable of this information. Anyone contacting Woodsprings Family Dentistry regarding your health information or account information whom is not listed or does not have your identifying information will be denied access to your information.
Note: After the initial completions of this form and additions and deletions must be given to Woodsprings Family Dentistry in writing.

Signature: _____

Print Name: _____

Date: _____