PATIENT AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO FAMILY AND FRIENDS

PATIENT NAME: _____ D.O.B._____

It is the policy of Waterford Dental Health to closely work with those involved in providing dental care to the patient. Unless otherwise indicated, the sharing of dental information will be restricted to the immediate family.

The patient may request that the list of people involved with their care be expanded or restricted. In these instances the patient will complete this form. The patient has the right to amend this information at anytime.

Please check all boxes where sharing of dental information is appropriate. Add any qualifiers or restrictions as required.

____ SPOUSE NAME: _____

____ CHILDREN NAME: _____

____ PARENT NAME: _____

____ OTHER FAMILY MEMBER: NAME: _____

____ OTHER – PLEASE SPECIFY: NAME : _____

Signed: _____ Date :_____

Signature of Patient or Legal Representative

I give permission for information to be left on my answering machine. Please check all that apply.

Home #: _____ Cell #: _____

____ Test and Radiograph Results

____ Appointments for tests/radiographs and hygienist/doctor visits

____ Information regarding prescriptions I am taking or changes in prescriptions

Signed: _____ Date: _____