Authorization to Discuss Protected Health Information

**Note: Completion of this form is optional. To be valid, form must be filled out completely, & include the information we are allowed to share.*

Patient Name: _____ DOB: _____

I Give Permission To: _____ Phone #: _____

Relationship to Patient: _____

To verbally discuss the following dental/medical & billing information about me.
(Check all that apply)

- ○ Scheduling/Appointment Information
- ○ Medical/Dental Information; including my symptoms, diagnosis, medications & treatment plan. (This may also include information about behavioral health, chemical dependency, prenatal care, pregnancy, family planning & STD testing & treatment.
- ○ Lab Test Results
- ○ Billing & Payment Information
- ○ Other

This authorization may be cancelled at any time in writing to this office, but will not affect any information already released. I understand that I should only sign if I want my provider to share my information with someone.

This Authorization Expires:

- ○ On this date: _____
- ○ Or when cancelled in writing

Signature of Patient/Guardian: _____ Date: _____

Witness If Patient Is Unable To Sign: _____ Date: _____

Reason Patient Is Unable To Sign: _____

*If authorized representative, please attach copies of supporting legal documentation