Straits Area Dental

Authorization to Disclose Information

Patient Name: _____

Date of Birth: _____

I, _____, grant permission for Straits Area Dental to release protected health/dental information for _____ (self or name of patient if parent or guardian) to the following:

Initial

_____ Spouse (name) _____

_____ Child (name) _____

_____ Other (name) _____

_____ Leave message on answering machine - Circle all that apply: Home Cell Work

OR

_____ **Information is not to be shared with anyone other than myself**

Please initial information that may be shared

_____ All Information

OR

_____ Appointment Information

_____ Treatment - Past, Present and Proposed including Fees

_____ Office Notes

_____ Test Results

_____ Account/Billing Information

Signature: _____

Date: _____

Straits Area Dental Representative: _____