Disclosure of Protected Health Information

Patient Name_____

Date of Birth_____

I hereby authorize that the protected health information regarding the above-named person be discussed with the following person(s):

Name _____Contact#_____

Relationship to patient_____

Name _____Contact#_____

Relationship to patient_____

Name _____Contact#_____

Relationship to patient_____

This authorization permits the disclosure of protected health information that includes but is not limited to test results, diagnosis, treatment and billing information. This authorization will remain in effect unless changed by me, through 12/31/2040, while I am a patient in the Tompkins Family Dental Group practice.

Signature _____ Date_____