Permission to Discuss

Protected Health Information

*Note: Completion of this form is optional. To be valid, this form must be filled out COMPLETELY, including what information you are giving us permission to share.

Patient Name: _____ **Date of Birth**:_____

I give permission to Mitchell Family Dental to discuss the following medical and billing information about me (check all boxes that apply):

☐ Scheduling/appointment information

☐ Medical information, including my symptoms, diagnosis, medications, and treatment plan.

☐ Billing and payment information

Mitchell Family Dental has my permission to discuss the above information with:

Name:_____ Phone:_____ Relationship to Patient:_____

Name:_____ Phone:_____ Relationship to Patient:_____

Name:_____ Phone:_____ Relationship to Patient:_____

I understand that I may cancel this permission at any time, but that cancelling it will not affect any information that has already been released. I understand that I do not have to sign this form, and that I should only sign it if I want my medical provider to share my information with someone. This authorization only expires when I cancel it in writing.

_____

Signature of patient/guardian Date