Heritage
Family Dental, P.C.

Permission to Share Medical/Dental Information

At Heritage Family Dental, we understand that the privacy of your personal information is important to you. Therefore, we will not discuss appointment dates/times, treatments or procedures, financial information, or any other personal information with anyone but you and those parties associated with your direct treatment (other medical/dental professionals, their treatment teams, and your insurance company), unless you give us written authorization to do so.

Please initial next to your choice. More than one may be selected.

____ I authorize my medical and dental information to be obtained and/or exchanged with the following individual(s) without restriction.

Name	Relationship

____ In the event of an emergency, I authorize the following individual(s) to be contacted. My medical and dental information is to be obtained and/or exchanged only for the purpose of notifying the authorized individual.

Name	Work#	Home or Cell#	Relationship

____ In the event Heritage Family Dental cannot reach me at my listed phone numbers, they may also call the following individual(s) to relay a message to me.

Name	Contact#	Relationship	May we leave a detailed message?	Message Restrictions
			Yes / No	□Please call the office □Appointment reminder □Other:
			Yes / No	□Please call the office □Appointment reminder □Other:
			Yes / No	□Please call the office □Appointment reminder □Other:

____ I DO NOT authorize any information to be obtained and/or exchanged with any individual.

These authorizations may be modified or changed at anytime with written consent from the patient only.

The authorizations on this form expire automatically after one year at which point, a new form must be completed. Upon expiration, NO medical or dental information will be obtained and/or exchanged with any individual.

Patient (Parent or Legal Guardian) Signature

Date