FAMILY DENTAL ASSOCIATES

PHI COMMUNICATION PREFERENCES

I authorize Family Dental Associates to disclose any and all details of my medical and dental diagnosis, treatment, and billing/claims information to the individuals listed below. This authorization is voluntary and I understand that I have the right to revoke this authorization by submitting a written request to the office. I understand that the information disclosed under this authorization may be disclosed again by the person or organization to which it is released. I understand that the below list may not be exhaustive and that my protected health information (PHI) may be disclosed to additional individuals based on my written authorization or as indicated in our Notice of Privacy Practices. This authorization shall remain in effect indefinitely unless revoked in writing by me.

❑ **I elect not to authorize disclosure to any individuals at this time**

			Check all that apply	
First and Last Name:	**Relationship:**	**Telephone Number:**	**Medical**	**Billing**

By signing below, I certify that I have read the above information and have had any questions answered.
My signature also certifies my understanding and agreement with the above information.

Patient Printed Name:
Patient DOB:
Patient/Legal Guardian Printed Name:
Relationship to Patient:
Signature:
Date: