Essential Endodontics

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CONSENT TO DISCLOSE MEDICAL INFORMATION

_____

Please Print Patient Name Date of Birth

Please CHECK ONE of the following:

☐ I give my permission to the employees of Essential Endodontics to disclose my protected health information to me AND the following friends and family:

NAME _____ RELATION _____

NAME _____ RELATION _____

NAME _____ RELATION _____

NAME _____ RELATION _____

☐ I request that all my protected health information be disclosed **ONLY TO ME** and to no other friends or family.

WHAT TYPE OF MESSAGE MAY WE LEAVE FOR YOU?

In an effort to serve you better, Essential Endodontics would like to know what type of message we may leave on your voicemail when contacting you. It is the policy of Essential Endodontics to call any phone number you provide to us.

When we contact you by calling you at any phone number you have provided we should (CHECK ONE):

- ☐ Leave a detailed message on your voicemail
- ☐ Leave a message with just enough information for you to call us back

I understand that I may revoke or change this authorization at any time by filling out another CONSENT TO DISCLOSE MEDICAL INFORMATION form. I understand that I will not be denied or refused treatment if I refuse to sign this authorization. I understand that the information used to disclose pursuant to this authorization may be redisclosed by the recipient and no longer be protected by Federal and State privacy laws. I understand that I have a right to receive a copy of this authorization if I request one. I also understand that this authorization will not expire.

_____

Signature of Patient or Representative Date

_____

Printed Name if not signed by patient Relationship

This form and any personal representative documentation will be scanned into the patient's medical record.