Authorization for Use or Disclosure of Protected Health Information

I, _____ authorize Arrowhead Family Dental and clinical staff to (check all that apply):

☐ Use the following protected health information, as granted by regulatory permission, for my dental treatment, insurance benefits, payment and health care operations.

> Protected health information concerning a patient may be disclosed (in accordance with state and federal laws) to a spouse, child, other family members or relative who requires information to assist in the patient's care and treatment, payment or health care operations.

Please list the following agents, proxies, representatives, and/or family members you authorize any necessary information that is directly relevant to patient care to be disclosed or released to:

_____

_____

_____

In the event that the Doctor or clinical staff at Arrowhead Family Dental is in need of information or requires authorization or consent regarding my patient information, I prefer to be contacted via:

☐**Phone** (call/text regarding treatment, appointments, and payments)

Home _____cell _____work _____

☐**Email** _____

Signature of Patient/Personal Representative _____

Print Patient/Personal Representative Name _____

Signature of Witness _____

Date _____