Personal Health Information Disclosure Agreement

I do hereby grant permission for Mansfield Dental Associates to disclose my personal health information to the following personal representatives(s): (spouse, sibling, parent, child, friend, etc.)

Representative's Name

Information to be disclosed (please check):

☐ Appointment dates and times

☐ Treatment plans and referrals

☐ Financial and billing

☐ Any other pertinent dental health information related to treatment at this office.

☐ None of the above

I understand that this permission will remain in effect unless a written cancellation has been provided to Mansfield Dental Associates

Patient Signature *

Date

Patient's Date of Birth *