



# Patient Authorization for Practice to Release Protected Health Information to Third Parties

By signing this authorization, I authorize Whole Family Dentistry personnel to use and/or disclose certain **Protected Health Information (PHI)** about me and or for the party or parties necessary to complete **Treatment, Payment and Healthcare Operations (TPO)**.

This authorization permits Whole Family Dentistry to use or disclose the minimum necessary **Individually Identifiable Health Information (IIHI)** to complete my TPO. This authorization includes all IIHI and PHI unless restricted as delineated below.

I authorize Whole Family Dentistry to share my Protected Health Information (PHI) with:

Spouse/Partner \_\_\_\_\_

Parent(s) \_\_\_\_\_

Sibling \_\_\_\_\_

Other \_\_\_\_\_ Relationship \_\_\_\_\_

Under no circumstances is my PHI to be shared with:

\_\_\_\_\_

I authorize Whole Family Dentistry to email my PHI to: \_\_\_\_\_

I authorize Whole Family Dentistry to leave me a voicemail message at: \_\_\_\_\_

Detailed (treatment and follow-up information, appointment time, etc.)

General (no detailed information)

A copy of Whole Family Dentistry's Notice of Privacy Practice is available to me at my request.

**I understand that this consent shall remain in effect until revoked in writing.**

\_\_\_\_\_  
Patient's Name (print)

\_\_\_\_\_  
Legal Guardian's Name

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Date