Whole Family Dentistry℠
Restorative and Aesthetic Care

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

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