Personal Health Information Disclosure Agreement

For Dover Pediatric Dentistry & Orthodontics, PLLC

I, _____, do hereby grant permission for Dover Pediatric Dentistry to disclose my personal health information to the following personal representatives(s): (spouse, sibling, parent, child, friend, etc.)

_____

_____

_____

_____

Information to be disclosed (please check):

- ☐ Appointment dates and times
- ☐ Treatment plans and referrals
- ☐ Financial and billing information
- ☐ 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 Dover Pediatric Dentistry & Orthodontics, PLLC.

_____ _____

Parent/Guardian Signature Date

_____

Printed Name of Parent/Guardian