Personal Health Information Disclosure Agreement

Patient's Name: _____ Patient's Date of Birth: _____

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

- ☐ Father _____
- ☐ Mother _____
- ☐ Grandparent _____
- ☐ Step Parent _____
- ☐ Aunt / Uncle _____
- ☐ Friend _____
- ☐ Other _____
- ☐ None

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.

Printed Name of Parent / Guardian: _____

Signature of Parent / Legal Guardian _____ Relationship: _____

Date: _____

Dover Pediatric Dentistry, 750 Central Ave Suite #K, Dover, NH 03820
Email: office@doverkidsteeth.com Tel: (603) 743-6000