General Dentistry
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Authorization for Information Disclosure

Would you like someone other than yourself to have access to your records (such as a spouse, child, etc)?

☐ **No**, I would not like anyone other than myself to have access to my protected health information.

☐ **Yes**, I would like someone other than myself to have access to my protected health information. **If you selected yes, please complete the information below.**

TO BE COMPLETED ONLY IF YOU SELECTED YES ABOVE

I, ____, do hereby authorize Harold S. Speight, D.D.S., P.A. to discuss the protected health information,

For Underage Patients: Name ________________________________ Patient DOB _____________________

with the following individual (s):

Name: ______________________________ **Relationship:** ______________________________

Name: ______________________________ **Relationship:** ______________________________

Name: ______________________________ **Relationship:** ______________________________

I hereby release Harold S. Speight, D.D.S., P.A. from any liability related to disclosure of confidential or privileged information.

Patient/Legal Guardian Signature _____________________________________ **Date** _______________________