

United States privacy laws (HIPAA) say that we (Z dentistry) cannot discuss any part of your care or bills with anyone unless we have your written permission. This information includes:

- Appointment times and reasons for the appointment,
- Tests and test results,
- Billing and
- If you are a patient at Z dentistry.

Please list the people with whom you allow Z dentistry to share your information.

I, _____, authorize the Doctor and Staff of Z dentistry to release my protected health information to the following:

Name	Relationship	Phone #
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Name	Relationship	Phone #
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Name	Relationship	Phone #
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Name	Relationship	Phone #
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I do not allow anyone to receive my protected health information.

Patient or Legal Guardian Signature	Date
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