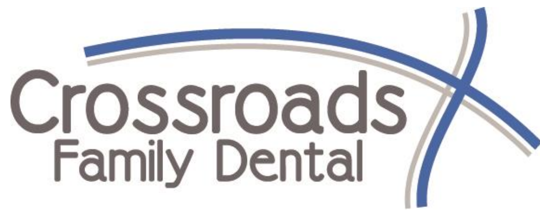

1314 Eagle Ridge Drive
Schererville, IN 46375
219-865-4095

Personal Health Information Disclosure Agreement

I, ________________________________, do hereby grant permission for Crossroads
(print name)
Family Dental, LLC to disclose my personal health information to the following personal representative(s): (Please indicate relationship in parenthesis: spouse, sibling, parent, child, friend, etc.)

____

____

____

____

Information to be disclosed (please check):

- o Appointment dates and times
- o Treatment information
- o Financial, billing, and insurance information
- o Any other pertinent dental health information related to treatment at this office.
- o All of the Above

I understand that this permission will remain in effect unless a written cancellation has been provided to Crossroads Family Dental, LLC.

____ ______________
Patient Signature Date

____
Patient's Date of Birth