Advance Family Dental

Patient Communication (HIPAA)

Patient Name _____ Date of birth_____

By Law, without your authorization, Advance Family Dental cannot communicate with your-

1-Spouse

2-Adult Child/Caregiver

3-Parent(s)

Please indicate below the names of people who we may communicate with regarding your treatment, appointments, medical, dental or account information:

_____ _____

Name of person to communicate with Relationship to you

_____ _____

Name of person to communicate with Relationship to you

_____ _____

Signature Date