AUTHORIZATION TO DISCUSS PROTECTED HEALTH INFORMATION

LAKESIDE DENTAL
FAMILY & COSMETIC DENTISTRY

I authorize Lakeside Dental to discuss my protected health information, including appointment information, treatment recommendations, insurance, billing, and payment information, with the individual(s) listed below.

Authorized Individual: _____

Relationship to Patient: _____

Phone Number (Optional): _____

Authorized Individual: _____

Relationship to Patient: _____

Phone Number (Optional): _____

Authorized Individual: _____

Relationship to Patient: _____

Phone Number (Optional): _____

This authorization does not permit the authorized individual to make healthcare decisions for me unless that individual has separate legal authority to do so.

☐ I understand that this authorization is voluntary and may be revoked at any time by providing written notice to Lakeside Dental. This authorization will remain in effect until I revoke it in writing.

Patient Signature: _____ Date: _____

☐ I do **NOT** authorize Lakeside Dental to discuss my protected health information with anyone other than myself, unless otherwise permitted or required by law.