Authorization for Release of Identifying Personal Health Information (PHI)

This form is to authorize individuals, other than other healthcare providers, to have access to your personal health information (PHI). For example, if you have family members or friends that call on your behalf, or take care of anything regarding yourself on your behalf, then you must authorize them by adding their names here and signing below.

I authorize the professional office of my dentist to release health information identifying me (including, if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about my mental health services) to the following persons:

Name	Relationship to Patient

Patient/Responsible Party Signature **Date**

Please include at least two contact persons to call in the event of an emergency.

Name	Relationship & Contact Number