WEIMERSKIRCH
FAMILY DENTAL LLC

Authorization to release Protected Health Information (PHI)

With your written permission, we may discuss your health information with a person(s) you designate. Your authorization allows team members at Weimerskirch Family Dental, LLC to discuss your health history, dental treatment, finances and appointments (including scheduling) with a designated adult such as a family member, friend, dental or medical practitioner. Please consider listing your emergency contact.

This patient is a(n): ☐ Adult (18 years or older) ☐ Minor Child ☐ Dependent Adult

Birthdate: _____

Telephone: _____

Patient Name: _____
First Middle Last

_____
Address City State Zip

☐ **Yes, I specifically authorize Weimerskirch Family Dental to disclose my Protected Health Information (PHI) to the following individual(s):**

1. _____
   Name Phone # Relation to Patient
2. _____
   Name Phone # Relation to Patient
3. _____
   Name Phone # Relation to Patient
4. _____
   Name Phone # Relation to Patient
5. _____
   Name Phone # Relation to Patient

☐ **No, I do <u>not</u> want my Protected Health Information shared with any individuals.**

This authorization is valid until otherwise revoked.

I may cancel this consent at any time by sending a written notice to the Privacy Officer, Weimerskirch Family Dental, LLC, 406 Wall St., East Dubuque, IL 61025. I understand that any discussion of information which was made before I cancelled my consent does not mean that my rights to confidentiality were breached.

_____ _____
Signature of patient or legal guardian Date

_____ _____
Name of legal guardian if other than patient Relationship to Patient