Family and Cosmetic Dentistry of Kokomo, PC
5111 Clinton Dr.
Kokomo, IN 46902
765-453-4369

Patient/Guardian Authorizations to Disclose Protected Health Information to Others

Patient Name: _____ DOB: _____ Today's Date: _____

To the patient: Family and Cosmetic Dentistry of Kokomo (FCDK) will attempt to follow your instructions to the extent the healthcare provider believes such disclose will not interfere with treatment. Please note the FCDK does not need specific authorization to disclose information for treatment or payment purposes consistent with it Notice of Privacy Practices.

Authorized by _____ Patient _____ Legal Guardian

(name): _____

Family and Cosmetic Dentistry of Kokomo may disclose **ALL** of my Protected Health Information to the following:

Name	Relationship	Contact info (phone/address)

1._____
2._____
3._____

The following information may **NOT** be disclosed to any of any of the above:

_____

_____

Duration/Expiration: Only the most recent singed Disclosure Authorization will be honored. This authorization will stay in effect during my treatment at FCDK unless it is revoked/revised by me in writing. I agree FCDK is not responsible for information that might be re-disclosed by those people who I have authorized to receive information.

Patient/Guardian Signature: _____

Date: _____

To receive copy of this form please provide email address: _____