HIPAA Consent to Share Dental Information

I,  authorize, Dr. Rodney P. Burton, DDS,

 (Print your name)

 to share the below indicated information to the following person(s):

Name:  Relationship: 

Name:  Relationship: 

Name:  Relationship: 

Please indicate the information that we may share:

([ ] ) Making appointments ([ ] ) Account or Financial Information

([ ] ) Confirming appointments ([ ] ) Make payments

([ ] ) Discussing treatment needed and/or preformed ([ ] ) Insurance information/benefits

\*This consent will remain valid from here forward unless otherwise informed by the patient and a new form is filled out\*

Signature:  Date: 

**If you do not authorize to have your information shared with anyone please fill out below:**

I  *do not* authorize to have my information shared with

 (Print your name)

anyone, including my spouse, or any other family member or guardian please sign and date below:

\*This consent will remain valid from here forward unless otherwise informed by the patient and a new form is filled out\*

Signature:  Date: 

For office use only:

Witness:  Date: 