PATIENT PERSONAL INFORMATION CONSENT

SOUTHWEST DENTISTRY

I, _____, give my permission to share information concerming the following:

- ☐ My Dental Treatment
- ☐ The Cost and Financial Arrangements for My Dental Treatment
- ☐ My Personal Health Information
- ☐ Other (Please Specify) _____

I give my permission to share the above noted information with the following:

- ☐ My Spouse (Name) _____
- ☐ My Parent(s) (Names) _____
- ☐ My Adult Child or Children (Names) _____
- ☐ Other (Please Specify) _____

- ☐ I, _____, DO NOT give my permission to share ANY information regarding my treatment, Financial Arrangements or Personal Health Information with the exception of what is outlined in the SOUTHWEST DENTISTRY LLC HIPPA policy.

Printed Patient Name: _____

Patient, Parent/Guardian Signature: _____

Date: _____

Practice Witness: _____

Date: _____

Cell Phone: _____ Ok to leave a message? Y ☐ N ☐

Home Phone: _____ Ok to leave a message? Y ☐ N ☐

Work Phone: _____ Ok to leave a message? Y ☐ N ☐