Authorization to Discuss Protected Health Information

Metro Dentalcare

Print Patient's Legal Name: _____

Previous Names: _____ Birth Date: _____

Person to Person Communication

To help with my care or billing, my care team may share information with the following individual(s) and/or leave a voicemail regarding my dental care at the following number:

Clinic Phone Number: _____

_____	_____	_____
First and last name	**Relationship to me**	**Best Contact Number**
_____	_____	_____
First and last name	**Relationship to me**	**Best Contact Number**

Please share:

- **Scheduling Information**
- **Dental Information**
- **Billing Information**
- **Nothing**

I understand the following:

- This consent applies to Metro Dentalcare and clinics using Metro Dentalcare shared electronic dental records. The clinic are listed at www.metro-dentalcare.com
- My care team will release all details to the person(s) named above.
- This form does not have an end date. If I want to change the information on this form, I will fill out a new form. If I want to add or remove people for person to person communication, I will fill out another form.
- Once my information is shared with the person or persons named above, it is no longer protected by privacy laws. Metro Dentalcare cannot prevent these persons from sharing my information with a third party.
- If I do not sign this form, I will still be treated.

_____ _____

Date/Time Signature of patient or authorized person

_____

Authorized person's authority to sign (proof required)

Reason patient is unable to sign: _____