Pauly Family Dental Group
1940 West Galena Blvd., Suite l0
Aurora, IL 60506
(630)892-8933

Disclosure of Protected Health Information

Patient Name____

Date of Birth________________________________

I hereby authorize that the protected health information regarding the above-named person be discussed with the following person's;

Name ____________________________________Contact#____________________

Relationship to patient____

Name ____________________________________Contact#____________________

Relationship to patient____

Name ____________________________________Contact#____________________

Relationship to patient____

This authorization permits the disclosure of protected health information that includes but is not limited to test results, diagnosis, treatment and billing information. This authorization will remain in effect unless changed by me, through 12/31/2040, while I am a patient in the Pauly Family Dental Group practice.

Name ____________________________________Contact#____________________

Relationship to patient____

Signature ______________________________________ Date_________________