McGann Family Dental

Personal Health Information Disclosure Agreement

I, _____ give McGann Family Dental permission to speak with the following people regarding my health status, including diagnosis, treatment options and plans, and payment for health service I receive.

The office may speak with:

Name _____ Relationship _____ Emergency # _____

Information to be released:

___ Treatment ___Diagnosis ___Schedule ___Payment ___Other

Name _____ Relationship _____ Emergency # _____

Information to be released:

___ Treatment ___Diagnosis ___Schedule ___Payment ___Other

Name _____ Relationship _____ Emergency # _____

Information to be released:

___ Treatment ___Diagnosis ___Schedule ___Payment ___Other

I authorize contact from McGann Family Dental to confirm my appointments, treatments, and billing information via:

___ Cell phone ___ Texting ___ Home phone ___Work phone ___ Email ___ All listed

I authorize information about my health to be conveyed via:

___ Cell phone ___ Texting ___ Home phone ___Work phone ___ Email ___ All listed

This consent is valid until such time as I provide a written revocation of it.

Patient Name: _____ DOB: _____

Signature: _____ Date: _____

McGann Family Dental