Authorization to Share Protected Health Information (PHI)

I hereby authorize Treasured Smiles Dentistry, LLC to release any medical/dental information as requested to the individuals I list below. The information that may be released will include, but is not limited to, medical/dental records, insurance information, appointment information, account information, and treatment information. This information can be released by phone, in person, by mail or via email.

I am aware that Treasured Smiles Dentistry, LLC cannot control how the recipient uses or shares this information and laws protecting its confidentiality may or may not protect this information once it has been disclosed to the recipient.

I understand that I may revoke this authorization at any time by notifying Treasured Smiles Dentistry, LLC in writing. I may see and copy the information described on this form if I ask for it and I am not required to sign this form to receive dental treatment.

Patient Name _____ Date of Birth _____

Release my protected health information to the following person(s) upon request:

Name: _____ Relationship _____

Name: _____ Relationship _____

The patient must sign this form to authorize Treasured Smiles Dentistry, LLC to release his/her PHI. If the patient cannot sign, only the patient's legal representative may sign. Patients 18 years or older must sign the form on their own behalf.

Signature of Patient or Patient's Representative_____ Date _____

Printed name of Patient's Representative (if applicable): _____

Relationship to Patient: _____

Treasured Smiles Dentistry, LLC / 10313 West Lincoln Highway, Frankfort, IL 60423
Phone: 815-806-1600/Fax 815-806-1633/email: mail@treasuredsmilesdentistry.com