AUTHORIZATION

Patient Name:_____ Date of Birth:_____

Patient to complete the following:

I permit Weston K. Morrill, D.M.D. and his staff to discuss my health information, in person or by telephone, with the following family members or friends involved in my medical/dental care:

NAME _____ D.O.B. _____ PHONE #_____
RELATIONSHIP _____

NAME _____ D.O.B. _____ PHONE #_____
RELATIONSHIP _____

NAME _____ D.O.B. _____ PHONE #_____
RELATIONSHIP _____

NAME _____ D.O.B. _____ PHONE #_____
RELATIONSHIP _____

This authorization is valid from_____ and expires on_____

I understand that I may refuse to sign this authorization.

I understand that you cannot condition provision of services or treatment based on whether or not I sign this authorization.

I understand that I have the right to revoke this authorization at any time by providing written notice to the organization. I also understand that the revocation is not applicable to information already disclosed while the authorization was in effect.

Signed:_____ Date:_____

Please file in patient chart and provide copy to patient at time of signature.