

Personal Health Information Disclosure for North Raleigh Periodontics



I, _____ do hereby grant permission for North Raleigh Periodontics to disclose my personal health information to the following persons (spouse, sibling, parent, child, friend, doctor's office)

Information that can be disclosed:

- Appointment dates & times
- Treatment plans & referrals
- Financial & Billing information
- Any other pertinent dental health information related to treatment at this office
- None of the above

I understand that this permission will remain in effect unless a written cancellation is has been provided to North Raleigh Periodontics

Patient Signature:

_____ Date: _____

Patient Date of Birth: _____