Personal Health Information Disclosure Agreement

Kerzner Orthodontics, P.C.

I, _____, do hereby grant permission for Kerzner Orthodontics, P.C., to disclose any **personal health information** regarding the listed patient below to the following personal representatives(s): (spouse, sibling, parent, grandparent, child, friend, etc.) Please list full names.

_____

_____

_____

_____

_____

Information to be disclosed (please check all that apply):

☐ Appointment dates and times
☐ Treatment plans and referrals
☐ Any other pertinent dental health information related to treatment at this office.
☐ None of the above (please explain)

_____

_____

I understand that this permission will remain in effect unless a written cancellation has been provided to Kerzner Orthodontics, P.C..

_____
Patient Name *(please print)*

_____
Signature

_____
Date

☐ I,_____, do **NOT** grant permission for any and all personal health information to be shared with any personal representative(s).