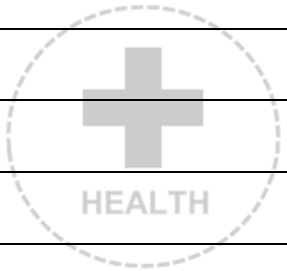
Personal Health Information &
Personal Financial Information
Disclosure Agreement

Kerzner Orthodontics, P.C.

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

PERSONAL HEALTH INFORMATION	PERSONAL FINANCIAL INFORMATION



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 **financial and billing information** to be shared with any personal representative(s).

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