Chesterfield Dentist

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I, _____, give permission to Chesterfield Dentist to discuss protected health information to the following individuals listed below:

Name(s):	Relationship:

This authorization shall remain in effect until I revoke it. I understand I may revoke this authorization at any time by notifying Chesterfield Dentist, preferably in writing.

Print Patient Name: _____

Signature: _____

If you are the patient's personal representative:

Relationship to patient: _____

Print Name: _____