Welcome to our office

Rodney P. Burton, D.D.S.

HIPAA Consent to Share Dental Information

I, _____ authorize, Dr. Rodney P. Burton, DDS,
(Print your name)
to share the below indicated information to the following person(s):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Please indicate the information that we may share:

( ) Making appointments
( ) Confirming appointments
( ) Discussing treatment needed and/or preformed
( ) Account or Financial Information
( ) Make payments
( ) Insurance information/benefits

This consent will remain valid from here forward unless otherwise informed by the patient and a new form is filled out

Signature: _____ Date: _____

If you <u>do not</u> authorize to have your information shared with anyone please fill out below:

I _____ *<u>do not</u>* authorize to have my
(Print your name)
information shared with anyone, including my spouse, or any other family member or guardian please sign and date below:

This consent will remain valid from here forward unless otherwise informed by the patient and a new form is filled out

Signature: _____ Date: _____

For office use only:

Witness: _____ Date: _____