A Family Dentistry
Todd Auerbach, D.D.S.

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INDIVIDUALS INVOLVED IN MY CARE

PATIENT NAME (LAST, FIRST, MI)	
ADDRESS	*CITY/STATE/ZIP*
DATE OF BIRTH	*SSN*

I understand that *A Family Dentistry/Todd Auerbach, DDS* is not always able to provide information regarding my care to others because my health information is protected by law. There are times when that information can by disclosed without my direct authorization if it is relevant to my care, such as times of emergency, if I am unconscious, or if I have a family member or friend with me when speaking to a health care professional.

However, at times it may be difficult for *A Family Dentistry/Todd Auerbach, DDS* to identify whether someone is a family member, friend, or other individual who is involved in my care, and I may not always be able to provide that information, such as if there is an emergency, if I cannot communicate, or for other reasons. To assist my healthcare providers in making these decisions, I am disclosing below any individuals involved in my care that can be contacted about or provided with information about my medical status, whereabouts, treatment instructions, medications, or other matters relevant to my care or medical status. I understand that I am giving *A Family Dentistry/Todd Auerbach, DDS* permission to disclose my protected health information to these individuals if and when *A Family Dentistry/Todd Auerbach, DDS* feels it is appropriate.

Name: ________________________________ *Relationship:* ___________________ *PH #:* _______________

Name: ________________________________ *Relationship:* ___________________ *PH #:* _______________

Name: ________________________________ *Relationship:* ___________________ *PH #:* _______________

This authorization is in effect until revoked by me. I have the right to revoke this authorization in writing at any time. I am signing this authorization voluntarily. No treatment, payment, or eligibility for benefits will be affected if I do not sign this authorization.

I, ______________________________________, agree to the above and understand this will remain in effect until I notify *A Family Dentistry/Todd Auerbach, DDS* **of any changes in writing.**

I, ______________________________________, have received a copy of this office's Notice of Privacy Practice, or read the copy in the office.

____ ____________________________________

Signature of Patient Date

____ ____________________________________

Signature of legal representative (state relationship to patient) Date