# Personal Health Information Disclosure Agreement
## River Forest Dental Studio

I, _____, do hereby grant permission for **River Forest Dental Studio**, to disclose my personal health information or the personal health information of my minor child _____ or mine to the following personal representatives(s): (spouse, sibling, parent, child, friend, etc.)

_____

_____

_____

_____

_____

Information to be disclosed (please check):

- Appointment dates and times
- Treatment plans and referrals
- Financial and billing information
- 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 **River Forest Dental Studio**.

_____

Patient Signature Date

_____

Patient's Date of Birth

_____

Witness Signature Date