Appointment of Designee for Receipt of Protected Health Information

This form is designed for you, the patient, parent or guardian to give Michael A Hess D.D.S. Inc. permission to disclose information regarding care you have received here at Michael A. Hess D.D.S. Inc. This could include appointment times and dates, billing information, test results and any dental information. It is your choice to allow us to release your information. If you do not wish to list anyone to receive your information please disregard this form. Only persons listed below will be given information. If you have not included a person to this list, they WILL NOT be given information of any type.

It is your responsibility to notify the staff, in writing, of any changes that need to be made to this form.

I, _____ herby designate and authorize the following individual(s) to receive my protected health information.

_____ Relationship to Patient_____
(Name)

_____ Relationship to Patient _____
(Name)

_____ Relationship to Patient _____
(Name)

or for _____ (for whom I am legal guardian). This is not a Power of Attorney and the named individual is not authorized by this document to make decisions regarding my health care.

I understand it is my responsibility to notify the staff, in writing , if this information changes.

_____ _____
Signature of Patient/Guardian Date