3391 Farm Bank Way
Grove City, Ohio 43123
614-594-2002
www.Guludental.com

I_____, Give my permission to share information concerning
_____My Dental Treatment
_____The Costs and Financial arrangements for my dental treatment
_____My Personal health information
_____Other _____.

I give my permission to share the above noted information with:

_____My Spouse (Name)_____

_____My Parent (S) (Names)_____

_____My adult Child or Children (Names)_____

_____Other _____

____I, _____**DO NOT** give my permission to share **ANY** information regarding my treatment, Financial arrangements or personal health information with the exception of what is outlined in the SOUTHWEST DENTISTRY LLC HIPPA policy.

Initial_____

Signed: _____ Date: _____

Witness: _____ Date: _____

Home Phone_____OK TO LEAVE MESSAGE? YES OR NO

Cell Phone_____OK TO LEAVE MESSAGE? YES OR NO

Work Phone_____ OK TO LEAVE MESSAGE? YES OR NO