Name DOB Date

Consent to Share Protected Health Information

I am allowing Golden Heart Dental to share all my Protected Health Information (PHI) with the person(s) listed on this form. This will include but is not limited to:

- When dental appointments are
- Findings from dental exams
- Dental treatment that has been completed or will be completed
- Medical history
- Xrays and photos taken in our office

By signing this consent form, I understand this will remain in place for 2 years following the date of signing or if I decide to revoke it sooner.

I consent to have Golden Heart Dental share my PHI with the following people:

_____

Name DOB (for verification purposes)

_____

Name DOB (for verification purposes)

_____

Name DOB (for verification purposes)

Signature Printed Name Date