Smith Family Dentistry

We respect your right to indicate who you prefer that we involve in your treatment or payment decisions and/or who we share your information with. Your information may include, but is not limited to medical condition, diagnosis, access to medical records, prescription pick-up and appointments. I grant permission for any member of the staff at Smith Family Dentistry to discuss my information with the authorized person(s) listed below. To ensure patient privacy, if they are not listed below our staff will not release any information regarding the patient. **Please note, however, that we may share your information as set forth in our Notice of Privacy Practices to other persons as needed for your care or treatment or the payment of services we have provided. Please update this information promptly if your preferences change.**

Please indicate the person(s) you prefer we share your information with below:

***Name:** _____ **Telephone:** _____ **Relationship:** _____

***Name:** _____ **Telephone:** _____ **Relationship:** _____

***Name:** _____ **Telephone:** _____ **Relationship:** _____

***Name:** _____ **Telephone:** _____ **Relationship:** _____

***Name:** _____ **Telephone:** _____ **Relationship:** _____

Patient Signature: _____ **Date:** _____

(To be signed by patient/parent or legal guardian if patient is a minor or otherwise not competent)