ROBINSON
FAMILY DENTAL

HEALTH/DENTAL INFORMATION DISCLOSURE AUTHORIZATION

I, _____, hereby authorize Robinson Family Dental and/or the staff of Dr Kaysha Robinson to disclose, discuss, and share information regarding my health, dental care, billing, records, or dental documentation with the following persons:

_____

_____

This authorization is understood to commence on the date noted below. This authorization is further understood to last the term of my treatment with Robinson Family Dental or until I notify Dr Kaysha Robinson and/or a member of her staff, in writing, that the authorization is terminated.

I have been advised of my information privacy rights under the Health Insurance Portability and Accounting Act of 1996 (HIPAA) and I am electing to disclose my health/dental information to the individual(s) listed above.

_____
Patient Name (please print)

_____
Patient Signature

_____
Date

8319 Preston Hwy # A Louisville Ky 40219
502-966-4031