Personal Health Information Disclosure Agreement for Dr. Andrew R. Cox, D.D.S

I, _____, do hereby grant permission for Andrew R. Cox, D.D.S., to disclose my personal health information to the following personal representatives (s): (spouse, sibling, parent, child, friend, etc.)

_____

_____

_____

_____

Information to be disclosed (please check):

- □ **Appointment dates and times**
- □ **Treatment plans and referrals**
- □ **Financial and billing information**
- □ **Any other pertinent dental health information related to treatment**
- □ **None of the above**

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I understand that this permission will remain in effect unless a written cancellation has been provided to Andrew R. Cox, D.D.S.

Patient Signature: _____ Date: _____

Patient Date of Birth: _____