J. Mark Bayless D.M.D., Inc.
Brandi Faia D.D.S.

Authorization for Release of Protected Health Information (PHI)

With your written permission, we may discuss your child's dental information with a person(s) you designate. Your authorization allows dental providers and staff members to discuss your child's health history, dental treatment, finances, and appointments, (including scheduling), with a designated adult such as a family member, friend, or dental/medical practitioner.

Patient's Name: _____

This patient is: □ Adult (18 years or older) □ Minor child □ Dependent adult

□**YES.** I specifically authorize Dr. Bayless' office to disclose my information to the following individuals:

1. _____ _____
Name **Relationship to the patient**

2. _____ _____
Name **Relationship to the patient**

3. _____ _____
Name **Relationship to the patient**

4. _____ _____
Name **Relationship to the patient**

5. _____ _____
Name **Relationship to the patient**

□**NO.** I **do not** want my information shared with any individuals.

This authorization is valid until otherwise revoked. I may cancel this consent at any time by sending a written notice to Dr. J. Mark Bayless. I understand that any discussion of information which was made before I cancelled my consent does not mean that my rights to confidentiality were breached.

_____ _____

Parent's Signature **Date**