CHART #_____
ACCOUNT #_____

401-115 APPENDIX A
AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Name of Patient _____ Birth Date _____

Street Address _____ City, State, Zip Code _____

I hereby authorize:

Dental Clinic of Marshfield, S.C.
306 W. McMillan Rd.
P.O. Box 929
Marshfield, WI 54449

To disclose my protected health Information to:

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Signature of Patient (or Legal Representative) _____ **Date** _____

Relationship to Patient _____ **Date** _____