Disclosure to Family and/or Friends

I, _____ give Hamann Dentistry permission to speak with the following people regarding my health status, including diagnosis, treatment options and plans and payment for health service I receive.

The office may speak with:

1. Name _____

   Relationship _____

   Information to be released (please check the following that apply):

   Treatment _____ Diagnosis _____ Schedule _____ Payment _____ Other _____

2. Name _____

   Relationship _____

   Information to be released (please check the following that apply):

   Treatment _____ Diagnosis _____ Schedule _____ Payment _____ Other _____

Signature: _____ **Date:** _____