I, ______________________________, give permission to Dr. Carly Klassen DDS to disclose and release my protected health information described below to:

Name(s): Relationship:

____ ____

____ ____

____ ____

Health Information to be disclosed:
My complete dental health record, (including but not limited to diagnoses, x-rays, prognosis, treatment, and billing).This information may be used to enable the persons I authorize to know and understand my condition and my treatment or treatment options, for treatment or consultation, for claims payment purposes, or related reasons. This authorization shall be effective for all past, present, and future periods.
(NOTE: You may revoke this authorization at any time by notifying Dr. Carly Klassen DDS in writing).

Name of the Individual Giving this Authorization: ____

Signature of the Individual Giving this Authorization: ____

Date: ______________________________________