Personal Health Information Disclosure Agreement

Central Virginia Dental Care, PLC

Dr. Richard W. Bates and Staff

I, _____________________________________ do hereby grant permission for Dr. Richard W. Bates and Staff, to disclose my personal health information to the following person representative(s): spouse, sibling parent, child, friend, etc.

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____

Information to be disclosed (please check):
Please circle or check all that apply:

Appointment dates and times _____
Treatment plans and referrals _____
Financial and billing information _____
Any other pertinent dental health information related to treatment at this office _____

I understand that this permission will remain in effect unless a written cancellation has been provided to Dr. Bates and Staff.

Patient Signature____Date:_______________