# Belknap Dental Associates

**40 Chestnut Street, Suite 2**
**Dover, NH 03820**
**(603) 742-4735**
**Fax: (603) 742-9911**

## Personal Health Information Disclosure Agreement

**I, _____, do hereby grant permission for Belknap Dental Associates, to disclose my personal health information to the following personal representatives(s): (spouse, sibling, parent, child, friend, etc.)**

_____

_____

_____

_____

**Information to be disclosed (please check):**

- ❑ **Appointment dates and times**
- ❑ **Treatment plans and referrals**
- ❑ **Financial and billing information**
- ❑ **Any other pertinent dental health information related to treatment at this office.**
- ❑ **None of the above**

.....

**I understand that this permission will remain in effect unless a written cancellation has been provided to Belknap Dental Associates.**

_____ _____

**Patient Signature** **Date**

_____

**Patient's Date of Birth**

_____ _____

**Witness Signature** **Date**