mint DENTISTRY
KIMBERLEY LATOUR

Patient Health Information Disclosure Over 18

Dear Patient,

We must have written consent to share any of your health information such as treatment, treatment pricing, full account reports and anything that you may want shared with a spouse, parent or guardian.

I, _____, do hereby grant permission for Mint Dentistry 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 (please explain)

I understand that this permission will remain in effect unless a written cancellation has been provided to Mint Dentistry.

_____ _____

Patient Signature Date

_____

Patient's Date of Birth

Kimberley M. Latour, DDS
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