Personal Health Information Disclosure Agreement
for Dr. Cynthia Elderkin, DDS

I, ________________________________, do hereby grant permission for Dr. Cynthia Elderkin, DDS, to disclose my personal health information to the following personal representatives(s): (spouse, sibling, parent, child, friend, etc.)

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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 Dr. Cynthia Elderkin, DDS.

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Patient Signature/Date

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Patient's Date of Birth