



INFORMATION SHARING CONSENT FORM

I, _____, give my permission to share information concerning:

- _____ My dental treatment
- _____ The costs and financial arrangements for my dental treatment
- _____ My personal health information
- _____ Other: _____

I give my permission to share the above noted information with:

- _____ My spouse (name): _____
- _____ My parents (names): _____
- _____ My adult child or children (names): _____

_____ I, _____, DO NOT give my permission to share ANY information regarding my treatment, financial arrangements or personal health information with the exception of what is outlined in the Lukens Family Dental HIPPA Policy.

Signed: _____

Date: _____