

**HIPAA – Authorization to Discuss**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, give my permission for Edgewater Dental’s office staff to

 (Print Patient’s Name)

discuss my treatment options, including payment options, with the following people:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name Relationship to Patient

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Print Name Relationship to Patient

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Print Name Relationship to Patient

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Print Name Relationship to Patient

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Signature of Patient Date

*Edgewater Dental – 3425 Highway 6 S, Ste. 108 – Sugar Land, TX 77478 – P/832.532.7120 – F/832.532.7637*