Stephen L. Vickers, DDS
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Houston, Texas 77069
281-440-1200

PERMISSION TO DISCLOSE TREATMENT WITH OTHERS

Today's Date: _____

I, _____, give permission to the staff of Vickers family Dental to discuss my treatment plan, treatment options, financial arrangements, and any health concerns associated with my treatment, with the following person(s):

Name	Relationship

Name	Relationship

HIPAA requires that we obtain your consent to use and disclose your protected health information for the purposes of carrying out treatment, obtaining payments, and carrying on healthcare operations for your care. By signing this form, you agree to allow Vickers Family Dental to discuss your treatment plan, treatment options, financial arrangements, and any health concerns associated with your treatment with the above person(s).

Signature of Patient	Date

Witness	Date