FANTARELLA
DENTAL GROUP
TOMORROW'S TECHNOLOGY TODAY

PERMISSION TO COMMUNICATE

Patient Name: _____ Date of Birth: _____

I authorize ***Fantarella Dental Group, PLLC*** to share my protected health information with family members or others designated by me below. This permission is NOT an authorization to release medical records, or a consent to treatment.

This permission also authorizes ***Fantarella Dental Group, PLLC*** to communicate with the authorized persons by phone (including voice messages), in person, or by other means acceptable by ***Fantarella Dental Group, PLLC.***

Name: _____

Phone Number: _____ Relationship to Patient: _____

Name: _____

Phone Number: _____ Relationship to Patient: _____

BILLING**

Responsible Party: _____ Relationship to Patient: _____

Responsible Party Signature: _____ Date: _____

_____ By checking this, I am revoking all current and/or previous Permission to Communicate forms

I understand that I may revoke this Permission to Communicate if I choose. Revoking this authorization does not apply to information that has already been released under this authorization. I have the right to inspect or copy the health information to be disclosed. If the disclosed information goes to a health care provider or a health plan covered by federal privacy laws, it will be protected by federal privacy laws. Information that goes to other persons or entities may not be protected by state or federal privacy laws and may be re-disclosed. I can revoke this Permission either by completing a new Permission to Communicate form and indicating my revocation on the form, or by notifying Fantarella Dental Group, PLLC in writing of my revocation. Communication should be sent to Fantarella Dental Group, PLLC at 127 Washington Avenue West Bldg., North Haven, CT 06473, ATTN: Privacy Officer

NOT EFFECTIVE UNLESS SIGNED AND DATED

Signature of Patient: _____ Date: _____

Printed Name: _____