# PRIVACY ADDENDUM

I understand that my private health information will only be released as needed for treatment, payment and healthcare operations. However, I authorize the following person(s) (spouse, significant other, parent, child, etc.) to have access to my dental records, to be included in discussions with my dentist, to be able to call in and discuss my treatment or billing history, and/or be present with me during an examination:

_____

_____

This authorization will expire upon my written request.

_____ _____

Patient Name Date

_____

Patient Signature