# Kirk Dental Associates HIPAA consent

_____

(please print name)

I authorize Kirk Dental Associates to disclose or speak about my protected health information (i.e. care, test results, account, appointment and premedication reminders) with the following person(s):

1. _____

   Name Relationship

2. _____

   Name Relationship

X:_____ Date:_____

(please sign)

***This document is valid for two years after the date that it was signed by the patient.***