Alternate HIPAA Disclosure

Patient Name: _____

This form authorizes ***the following listed individuals*** access to my diagnosis, treatment, account and billing information related to my care by Kai D Hart, DMD or Hart Dental Care. This form also acts as a waiver of my HIPAA rights, as disclosure of potential health information, treatment and future visits may be presented to the listed individuals with my full consent. I understand that I may revoke this designation at any time by contacting Hart Dental Care in writing.

Name of Person	Relationship	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ _____

Signature of Patient Date