Amato Orthodontics S.C.

17 East Waldo Boulevard
Manitowoc, Wisconsin 54220
phone: (920)684-7103 fax: (920)684-5570
www.amatoorthodontics.com

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

The purpose of the Notice of Privacy Practice is to describe to you how Amato Orthodontic S.C. may use and disclose you or your child's protected health information. Amato Orthodontics S.C. will not make any unapproved disclosure of your PHI without your written authorization*.

We understand that a relative or friend may possibly bring your son/daughter in for their routine orthodontic visit. We are unable to give any information or additional instructions concerning your son/daughter unless we have written permission.

I_____
(Name and Relationship to Patient)

hereby agree to permit Amato Orthodontics S.C. to disclose any protected health information or additional instructions concerning _____'s orthodontic treatment to the
(Patient's Name)

following: (Examples: spouse, relative, friend, etc. This DOES NOT apply to other physicians, insurance carriers, or attorneys).

Name: _____ Relationship: _____
(First and Last Name)

Name: _____ Relationship: _____
(First and Last Name)

Name: _____ Relationship: _____
(First and Last Name)

Name: _____ Relationship: _____
(First and Last Name)

If you have any questions concerning this Authorization to Disclose Protected Health Information, please do not hesitate to ask. Thank you.