FLOSS
FAMILY DENTAL & SURGICAL CENTER

Authenticate to Disclose PHI
(Patient/Protective Health Information)

Patient Name: _____ Date of Birth: _____

□ Sending records to Floss Family Dental; please check this box & fill out the boxes below	□ Sending records to another facility: please check this box & fill out the boxes below
From: Name: _____ Address: _____ _____ Phone: _____ Email: _____ Fax: _____	**From**: Floss Family Dental & Surgical Center 5760 S 86th Dr. Ste 2 Lincoln, NE 68526 Phone: 402-484-5760 Fax: 402-484-0229 Email: flossfamilydental@gmail.com
To: Floss Family Dental&Surgical Center 5760 S 86th Dr. Ste 2 Lincoln, NE 68526 Phone: 402-484-5760 Fax: 402-484-0229 Email: flossfamilydental@gmail.com	**To**: Name: _____ Address: _____ _____ Phone: _____ Email: _____ Fax: _____

Additional minor children to be included (adults require a signature):

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

If leaving the practice, please provide the following (check all that apply):

_____ Moving _____Insurance

_____Other; reason _____

I authorize the release of dental records of the patient(s) as indicated above.

Signature: _____ **Date:** _____
(if a minor, signature of guardian)