Arlington Dental Group

FARIBA ESBAH, D.M.D. GENERAL DENTIST
DENTISTRY FOR ADULTS AND CHILDRE

Designate Individuals Authorization Form

I hereby authorize one or all of the designated parties listed below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Please give the name (s) of the individual (s) who you will allow to receive any part (s) of your health record.

Authorized Designees:

Name: ______________________________ **Relationship** ________________

Name: ______________________________ **Relationship** ________________

Name: ______________________________ **Relationship** ________________

Name: ______________________________ **Relationship** ________________

Patient's Name : ______________________________

Patient's Signature: ______________________________ **Date:** ____________

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