

Permission to Share Private Health Care Information

I _____ (print your name), effective _____ (date), give the office of Robert A. Levy, D.M.D., LLC, permission to share my protected health care information with the following individuals. This permission will be valid unless revoked in writing.

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

Signature of patient _____ Date _____