DR. WAYNE B. ERICKSON, D.D.S
130 SOUTH SENECA
NEWCASTLE, WYOMING 82701
TELEPHONE 307 746-4600

Date:

Written Authorization for release of PHI

I hereby authorize Erickson Family Dental Center to discuss my protected health information (PHI) with the following person. Should I wish to revoke this authorization, I understand I must do so in writing.

Name _____Phone _____ Relationship _____

Name _____Phone _____ Relationship _____

Name _____Phone _____ Relationship _____

Print Name of patient authorizing release _____

Patient Signature authorizing release _____ Date _____
(required if the patient is a minor or an adult unable to sign)