Watts Family Dentistry

H. William Watts III, D.D.S.

Kathryn L. Watts, D.D.S.

CONTACT INFORMATION FOR PROTECTED HEALTH INFORMATION

This states the request that the following be followed for disclosure of my Protected Health Information. Protected Health Information would include your name, diagnosis (es), test results and dates of services.

Please Check All that Apply

You may disclose information to my family members and (or) non- family members. Please list below their name (s), contact phone number and their relationship.

Name	Phone number	Relationship

_____ _____

Printed Name Date

_____

Signature