Authorization to Disclose Information

I authorize you to disclose to my spouse, and/or either of both of my parents (if I am covered under my parents' insurance policy or they are otherwise responsible for payment for services on my behalf) either orally or in writing, all medical and dental treatments, costs and other matters relating to the services you perform for me, my spouse and my children, if any ("My Family") and waive any confidentially rights I may have under applicable law for such disclosures. In this manner I anticipate that you will provide a consolidated statement of account for My Family. I will inform you in writing if I want to revoke this Family disclosure authorization of if I will require separate account statements for any member of my family.

In addition to My Family, I also authorize you to disclose to the individual(s) identified below ("Designated Individuals") either orally or in writing all medical and dental treatments, costs and other matters relating to the services you to the services you perform for me.

Designated Individuals

Name	Relationship to you, if any

---Patient Signature