Dr. William S. Neale, BA, DDS, MS
Periodontics & Dental Implants
2106-A Virginia Dr Wichita Falls, TX 76309
940-322-0758

Patient Authorization to Disclose Protected Health Information Family/Provider of Care

I, _____(name) , understand that Dr. William S. Neale and the office staff are authorized to disclose my protected health information by telephone or in person to the people I have listed below.

Name(s) of person(s) authorized by this form to disclose my protected health information:

Name/Relationship	**Allowed Information**		
_____	Appointment	Dental	Billing
_____	Appointment	Dental	Billing
_____	Appointment	Dental	Billing

I understand that I have the right to revoke anyone listed above and that the revocation must be done in writing . ALL revocations must be sent to Dr. William S Neale's office and are not effective until received by the front office staff.

Upon My signature, I acknowledge that I fully understand and accept the terms of this authorization.

Patient's Signature _____