BRUCE C. WETMORE, D.D.S., P.L.L.C.

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing, I authorize, Bruce C. Wetmore, D.D.S., P.L.L.C. to use and disclose certain protected health information about me to:

Spouse and/or family members names:_____

Other Doctors_____ Insurance Co_____

Schools_____ Attorneys_____ Work Comp_____

Other_____

I do not have to sign this authorization in order to receive treatment from Bruce C. Wetmore, D.D.S. I have the right to refuse to sign this authorization.

_____ _____

Patient/Parent/Guardian Signature Today's Date

_____ _____

Print Patient Name Patient's Date of Birth

Authorization must be received for reasons other that routine treatment, payment or healthcare operations. Bruce C. Wetmore, D.D.S., P.L.L.C. will not furnish PHI without a signed authorization