Merrimack Dental Associates

**HIPAA authorization for disclosure of health information**

I, _____ DOB: _____
give Merrimack Dental Associates my permission to disclose all information regarding my treatment, appointment times and dates, as well as insurance and billing information to the following person or persons.

Name: _____ DOB: _____

Relationship to the patient: _____

Name: _____ DOB: _____

Relationship to the patient: _____

***This authorization may be revoked at any time upon your written request.***

Patient Signature: _____ Date: _____

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**Fax: 603-424-3620**