Stone & Johnson at Edinborough Dental
3300 Edinborough Way, Suite 210, Edina, MN 55435
phone: 952-831-1112 fax: 952-831-1839

INDIVIDUALS INVOLVED IN MY CARE

PATIENT NAME (LAST, FIRST, MI)	
ADDRESS	*CITY/STATE/ZIP*
DATE OF BIRTH	*Last 4 digits of SSN*

I understand that Stone & Johnson at Edinborough Dental is not always able to provide information regarding my care to others because my health information is protected by law. There are times when that information can be disclosed without my direct authorization if is relevant to my care, such as times of emergency, if I am unconscious, or if I have a family member or friend with me when speaking to a health care professional.

However, at times it may be difficult for Stone & Johnson at Edinborough Dental to identify whether someone is a family member, friend, or other individual who is involved in my care, and I may not always be able to provide that information, such as if there is an emergency, if I cannot communicate, or for other reasons. To assist my healthcare providers in making these decisions, I am disclosing below any individuals involved in my care that can be contacted about or provided with information about my medical status, whereabouts, treatment instructions, medications, or other matters relevant to my care or medical status. I understand that I am giving Stone & Johnson at Edinborough Dental permission to disclose my protected health information to these individuals if and when Stone & Johnson at Edinborough Dental feels it is appropriate.

*NAME:*________________________________*Relationship:*___________________*PH #:*_______________________

*NAME:*________________________________*Relationship:*___________________*PH #:*_______________________

*NAME:*________________________________*Relationship:*___________________*PH #:*_______________________

This authorization is in effect until revoked by me. I have the right to revoke this authorization in writing at any time. I am signing this authorization voluntarily. No treatment, payment, or eligibility for benefits will be affected if I do not sign this authorization.

I, ______________________________, AGREE TO THE ABOVE AND UNDERSTAND THIS WILL REMAIN IN EFFECT UNTIL I NOTIFY Stone & Johnson at Edinborough Dental OF ANY CHANGES IN WRITING.

SIGNATURE OF PATIENT	*DATE*
SIGNATURE OF LEGAL REPRESENTATIVE (state relationship to patient)	*DATE*