Elite Endodontics of NH
Practice Limited to Endodontics and Microsurgery

182 Central Street, Hudson, NH 03051
1310 Hooksett Road, Hooksett, NH 03108
60 Whittier Hwy, Unit 1, Moultonborough, NH 03254
603.882.5455

Patient Authorization to Disclose Health Information

Patient Name: _____ Date of Birth: _____

I hereby authorize Elite Endodontics of NH to speak with and disclose information related to my dental and endodontic care to the individual(s) listed below. This may include, but is not limited to:

- Appointment information
- Diagnosis and treatment plans
- Financial and billing information
- Medical history and medications
- Insurance-related matters

Authorized Person(s)

Name: _____

Relationship: _____

Phone Number: _____

Name: _____

Relationship: _____

Phone Number: _____

Patient Rights & Acknowledgement

I understand that I have the right to revoke this authorization at any time in writing. I also understand that this form does not authorize the release of full dental records unless specifically requested.

Signature of Patient or Legal Representative: _____ Date: _____

Printed Name: _____

Relationship to Patient (if applicable): _____