Sloan K Jorgensen, DDS
823 E Colonial Avenue
Moses Lake, WA 98837

PATIENT NAME ____

ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosures in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below:

ANY MEMBER OF MY IMMEDIATE FAMILY	YES	NO
SPOUSE ONLY (name) ____	YES	NO
OTHER (Please specify) ______________________________________	YES	NO

____ ______________________
Name of Patient or Personal Representative Relationship

____ ______________________
Signature of patient of personal representative date