# AUTHORIZATION TO RELEASE PERSONAL HEALTH INFORMATION (PHI)

I hereby authorize the office of Dr. Reem Haj-Ali and staff members to schedule, discuss or release my personal health information as necessary for dental care to:

Name: ________________________________

Name: ________________________________

Name: ________________________________

Name: ________________________________

Patient Name: __________________________

______________________________________ ______________________
Signature of patient/Authorized Representative Date

______________________________________ ______________________
Witness Date

Authorization is valid for 12 months from the date of signature

4839 W. 135th St. Leawood, KS 66224
Phone: 913.681.5500 / Email: info@dreemdentistry.com