INFORMATION RELEASE AUITHOAIZATION

I, _____, ALLOW THE BELOW NAMED PERSON(S) TO HAVE

CIRCLE ONE: (PATIENT / PARENT OR GUARDIAN)

ACCESS TO THE SPECIFIED DENTAL lNFORMATlON (FOR_____.)

(PATIENT NAME 1F A MINOR)

NAMES: RELATION/PHONE#:

_____ _____

_____ _____

PLEASE CIRCLE WHAT CAN BE RELEASED:

*XRAYS

*BALANCE/PAYMENT INFO

*TREATMENT PLANS

*APPOINTMENT lNFO

*CONFIRM/CANCELAPPOINTMENTS

*LEAVE DETAILED MESSAGES

*IF A MINOR) BRING/PICK 1JP FROM APPOINTMENTS

*IF A MINOR) CONSENT FOR TREATMENT

BEST PHONE NUMBER TO REACH YOU: _____

DO NOT LEAVE DETAILED MESSAGES DO NOT SEND DETAILED TEXT

MAY LEAVE DETAILED MESSAGE MAY SEND DETAILED TEXT

YOU WILL STILL RECEIVE APPOINTMENT REMINDERS VIA TEXT, PHONE AND EMAIL. THOSE MUST BE CANCELLED AFTER YOUR FIRST REMINDER IF NEEDED.

X_____ _____

PATIENT/ GIJARDlAN SIGNATIJRE DATE