Authorization to Communicate Health Information

Patient Name _____ Date Of Birth_____

*You may release information on my dental condition(s) to the following individuals:

1._____

2._____

3._____

4._____

This authorization will remain valid from the date of this signed document unless revoked by patient or legal guardian. This authorization applies to all episodes of care and treatment, including but not limited to results, diagnoses, and appointments.

_____

Patient or Legal Guardian Date