AD DENTISTRY

GENERAL DENTISTRY

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CONSENT TO SHARE CONFIDENTIAL DENTAL INFORMATION

To be valid, this form must be filled out COMPLETELY, including what information you are giving us permission to share.

PATIENT'S NAME: _____DOB: _____

I HEREBY AUTHORIZE MY DENTAL CARE TO SHARE:
Any of my medical/dental information.
Payment, Billing and Insurance information.
My lab results.
My appointment dates, times, cancellations, and reasons for the visits.
My medications I take.
The following instruction such as Rx, appointment reminders, and so on.
(specify): _____

WITH THE FOLLOWING NAMES:
Full Name: _____ Relationship: _____Ph. Nbr: _____
Full Name: _____ Relationship: _____Ph. Nbr: _____

I understand that I may cancel this consent at any time (by writing to AD Dentistry), but that cancellation will not affect any information that has already been released.
I understand that I do not have to sign this form, and that I should only sign it if I want my dental provider or clinical staff to share my information with someone.
If there is no expiration date specified, this authorization will expire one (1) year after the date is signed.

Signature: _____ Date: _____

**Relationship to minor patient (parent or legal guardian): _____*
If you are not the minor patient's parent, you must give us proof of guardianship (i.e. court order or power of attorney).

Witness signature: _____ Date: _____