Dr. Leslie McGuinn Davis | Dr. Lauren Palmer Freitag

Dr. Melissa Thomas Durand | Dr. Michael Palmer

Dental Information Release and Authorization

Name: _____ Date of Birth: _____

[ ] I authorize the release of information including the entire contents of dental record, including diagnosis, treatment details and financial information.

This information may be released to:

[ ] Spouse_____

[ ] Child(ren) _____

[ ] Other _____

[ ] Information is not to be released to anyone.

I understand that I have the right to revoke this Authorization, in writing, at any time by notifying this office. Such revocation will not affect actions taken by the requesting person prior to the date he or she received the written revocation. I also understand information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and will no longer be protected by this rule. I understand that my health care provider cannot condition treatment on whether I sign this Authorization.

This Authorization will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell number: _____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

Signed: _____ Date: _____/_____/_____

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