Disclosure of Information

I, _____, authorize the following people to accompany, obtain dental records information/ discuss dental treatment/ and appointment scheduling for _____.

- _____ Relationship to patient_____ DOB: _____
- _____ Relationship to patient_____ DOB: _____
- _____ Relationship to patient_____ DOB: _____
- _____ Relationship to patient_____ DOB: _____
- _____ Relationship to patient_____ DOB: _____

I refuse to share, discuss, and do not give authorization to any other person other than myself to obtain any of my dental records nor to discuss any dental treatment. If you refuse, please initial the box. ☐

Date: _____

Patient/ Parent/ Guardian Signature: _____

Relationship to Patient _____

NOTE: PHOTO ID IS REQUIRED FOR EACH PERSON AT THE TIME OF VISIT.