laurichdentistry
smile driven

Consent to Release and Share Medical/Dental/Financial Information

I, _____ authorize **Laurich Dentistry** to disclose/release my personal dental health and medical health information to the below names that I have named on this form. I authorize **Laurich Dentistry** to disclose my financial and insurance information as well.

I do understand by doing so that my personal information may no longer be protected by law.

Please fill in the names of person/person's whom you authorize your personal information to be disclosed and shared with.

Name_____

Relationship_____

Phone Number _____

Name_____

Relationship_____

Address _____

Phone Number _____

___ Please check here if you are signing as a personal representative on someone behalf. Please attach the appropriate documentation. (Power of Attorney, Guardian, Guardian Atlitam,)

Signiture

_____ Date_____

(Adult Patient Name)

Witness

_____ Date_____

(Office Personel)