ORAL AND DENTAL
IMPLANT SURGERY

Authorization to Discuss Healthcare

Patient's Name: _____ Date of Birth: ___/___/___

[ ] I acknowledge that I have been offered a copy of Oral & Dental Implant Surgery's Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding this notice.

I authorize my provider and staff of Oral and Dental Implant Surgery to discuss my healthcare with the following:

_____ Relationship _____

_____ Relationship _____

_____ Relationship_____

[ ] I do NOT authorize my healthcare to be discussed with anyone.

May we leave a message for you on an answering machine? [ ] Yes [ ] No

May we leave a message with someone at your home regarding an appointment? [ ] Yes [ ] No

If yes, with whom can we leave a message? _____

I understand that I may revoke this authorization at any time by notifying Oral and Dental Implant Surgery, in writing, except to the extent that:

1) Action has been taken in reliance on this authorization.

_____

SIGNATURE (person/patient authorizing release):

_____ _____

Relationship to Patient: Date