Consent to Discuss Patient Information

_____ _____

Printed Name of Patient Date of Birth

_____ _____

Street Address City, State, Zip

_____

Phone Number

I permit Alaska Center for Dentistry, their physicians, nurses and other personnel ("Health Care Providers") to discuss health information, in person or by telephone, with the following family members or friends involved in my medical or dental care:

This authorization is limited to discussions regarding the following medical or dental condition(s)

- □ Everything
- □ Only Treatment
- □ Only Financial

Name	Relationship	Phone Number
1._____	_____	_____
2._____	_____	_____

If at any time, I do not want my consent to continue to be permitted, I must notice my Dental Care Provider.

Patient Signature/Parent: _____ Date: _____

If this release is signed by a representative on behalf of the patient, complete the following:

Representatives Name: _____

Relationship to Patient: _____