

**AUTHORIZATION TO RELEASE AND DISCUSS DENTAL INFORMATION**

Please provide all family members or friends you want us to be able to speak with about your dental treatment and care. You may opt out by checking the "Do not release information" box below.

I give the following named person(s) authorization to take messages or speak with the office of Tenaflly Dental Spa, on my behalf, regarding (please check all items authorized):

- Name of authorized person(s): \_\_\_\_\_ Relationship: \_\_\_\_\_  
Phone number: \_\_\_\_\_  
 Appointments       Financial       Dental Treatment       Insurance       Other

- Name of authorized person(s): \_\_\_\_\_ Relationship: \_\_\_\_\_  
Phone number: \_\_\_\_\_  
 Appointments       Financial       Dental Treatment       Insurance       Other

- Name of authorized person(s): \_\_\_\_\_ Relationship: \_\_\_\_\_  
Phone number: \_\_\_\_\_  
 Appointments       Financial       Dental Treatment       Insurance       Other

---

DO NOT release information to anyone

With my signature below, I acknowledge and understand that this information will be kept in my medical record and the above parameters will remain in effect until revoked by me in writing. It is my responsibility to notify my healthcare provider(s) should I wish to change one or more contacts listed above.

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date of birth

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date