Consent to Release Patient Dental Information

I authorize and direct Parkway Vista Dental, PLLC to release the following dental information:

_____ Labs
_____ X-Rays
_____ Proposed Treatment
_____ Completed Treatment

To the following:

Family member, please specify name & relationship

_____
_____
_____

Best method for us to reach patient (please check all that apply)

____ Home Phone # _____
Okay to leave on answering machine/voice mail
____ Work Phone # _____
Okay to leave on answering machine/voice mail
____ Cell Phone # _____
Okay to leave on answering machine/voice mail

____ Release information to me only

_____ _____
Patient Signataure Date