anderson
DENTAL

CONSENT TO INFORM

Patient Name: _____ Date _____

We respect your privacy regarding your dental information*. With your written consent below we may share information with your spouse.

Spouses Name: _____

Patient Signature: _____

We understand you may have family members that need access to your information for various reasons such as billing, language interpretation, and patient convenience/support.

Please list the names of the adults who are authorized to have access to your dental information*.

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

I authorize Anderson Dental to disclose my dental information* to the above named parties.

_____ _____

Signature of Patient or Authorized Representative Date

**dental information includes but is not limited to: billing, treatment, insurance, and medical history*