Authorization to Release and Discuss Information

Provide below any person that you would want us to be able to speak to about your dental treatment and care. You could always check the "Do not release any information" box below if you would like to opt out.

I give the following person(s) authorization to take messages or speak with the office of J-Town Comprehensive Dental Center, on my behalf, regarding the items I check below:

Name of authorized person(s): _____ Relationship: _____
Phone number: _____

☐ Financial ☐ Treatment ☐ Insurance ☐ Appointments

Name of authorized person(s): _____ Relationship: _____
Phone number: _____

☐ Financial ☐ Treatment ☐ Insurance ☐ Appointments

Name of authorized person(s): _____ Relationship: _____
Phone number: _____

☐ Financial ☐ Treatment ☐ Insurance ☐ Appointments

Name of authorized person(s): _____ Relationship: _____
Phone number: _____

☐ Financial ☐ Treatment ☐ Insurance ☐ Appointments

☐ **DO NOT** release my information to anyone other than me

With my signature below, I acknowledge and understand that this will be kept with my medical record and the above person(s) will have access to my health information until I have revoked this information in writing. It is my responsibility to notify J-Town Comprehensive Dental Center if I wish to change anything I have listed above.

_____ _____
Patients Name Witness

_____ _____
Patients Signature Date