Consent Disclosure Form for Family or Other Individuals

This form is for the purpose of authorizing someone other than yourself to communicate with our staff with regard to your health and dental information.

Patient providing Authorization:

Name (Last, First)	☐ Patient is providing Verbal Consent
Date of Birth mm/dd/yyyy	Telephone # (xxx) xxx-xxxx

The person listed is authorized to access my medical information:

Name (Last, First)		☐ Patient is providing Verbal Consent
Street Address		Telephone # (xxx) xxx-xxxx
City	Province	Postal Code
Relationship with patient (i.e. spouse, partner, father, mother, guardian, son, daughter, in-law, power of attorney, etc.)		

Additional person listed below is also authorized to access my medical information:

Name (Last, First)		☐ Patient is providing Verbal Consent
Street Address		Telephone # (xxx) xxx-xxxx
City	Province	Postal Code
Relationship with patient (i.e. spouse, partner, father, mother, guardian, son, daughter, in-law, power of attorney, etc.)		

Information to be released:

☐ All information (Except the following subject: _____)

☐ Financial information for the purposes of satisfying outstanding accounts

☐ ONLY for the following subject (e.g. appointment scheduling): _____

This authorization will remain effect until revoked by you. If you wish to limit the duration of this authorization, please specify the end date: ☐ _____

I authorize the release of my health and dental information in accordance with the specifications listed above. I will receive/retain a copy of my signed authorization, if requested. Documented (signed or verbal) consent will be recorded in my health record.

Signature of Patient _____ Date _____