DENTAL SURGEONS & IMPLANT CENTERS
OF FALL RIVER AND DARTMOUTH

Patient Consent for Use and Disclosure of Protected Health Information

Name____Date of Birth____/____/____

Release of Information

( ) I authorize the release of information including protected health information and /or medical record-billing information. The information may be released to:

( ) Spouse/Significant other:____

( ) Child(ren) (18yrs of age or older):____

( ) Parent/Guardian:____

( ) Other:____

The Release of Information will remain in effect until terminated by myself in writing.

Messages

Please call ( ) my home ( ) my work( ) my cell number ( ) email___________________

If unable to reach me:

( ) you may leave a detailed message

( ) please leave message asking me to return your call

( ) other:____

The best time to reach me is (day) ___________________between (time)____________

Signature____ Date____/____/____