

Goodall Family Dentistry

AUTHORIZATION TO RELEASE DENTAL INFORMATION

1. AUTHORIZATION TO LEAVE MESSAGES ON YOUR ANSWERING MACHINE:

_____ **YES** I **AUTHORIZE** the staff of Goodall Family Dentistry to leave messages regarding appointments on my answering machine and/or voice mail.

_____ **YES** I **AUTHORIZE** the staff of Goodall Family Dentistry to leave messages regarding my dental information on my answering machine and/or voice mail.

_____ **NO** I **DO NOT AUTHORIZE** any dental information to be left on my answering machine.

2. AUTHORIZATION TO DISCUSS INFORMATION WITH SPOUSE AND/OR SIGNIFICANT OTHER AND/OR CHILDREN:

_____ **YES** I **AUTHORIZE** the staff of Goodall Family Dentistry to discuss information related to my care with my spouse and/or significant other and/or children.

_____ **NO** I **DO NOT AUTHORIZE** the discussion of my care with anyone other than myself.

3. Please list anyone we may speak to about your dental condition. Please include spouse, significant other, children, and/or other people we would be allowed to release information to if you are not available.

Name and Telephone Number

Relationship

4. Emergency contact: _____

Print Patient Name

Date of Birth

Date

Signature of Patient or Person Acting on Patient's Behalf

Relationship

Right to Revoke: You may revoke this authorization at any time except to the extent that we have relied on the authorization. To revoke this authorization you must submit a written revocation to the following address: Goodall Family Dentistry, 3100 NC Highway 55, Cary, NC 27519.

I REQUEST A COPY OF THIS FORM: ____ YES ____ NO

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