*Beverly Hills Dental*
*Dr. Raphael Lewis D.D.S.*

**Patient Consent & Authorization for Release of Information**

I, _____, authorize release of my confidential information to:
(Please Print)

*Please list the first and last names of the individuals that will be authorized the release of your confidential information: (i.e. Husband/Wife, Family members, Caregivers, etc.)

_____
(Please Print)

_____
(Please Print)

I understand that this consent gives the individuals listed above, access to confidential information this office may have on you. You may revoke this consent at any time by giving a written revocation to this office. The revocation we receive will take effect on the date it is received. I also understand that I do not have to sign this form to receive care.

**Signature of patient**: _____ **Date:** _____

## OR

IF you do not wish to release your information to anyone, please select our opt-out option

- ○ I do not wish to release my information to anyone. I realize by selecting this option, no one else will be able to access my information.

**Signature of patient**: _____ **Date:** _____

**OR**

**Parent/Guardian Signature**

Name of Parent/Guardian: _____
(Please Print)

Signature of parent/Guardian: _____ Date: _____

Relationship to Patient: _____