



This is to certify that I _____ request that my
dental information only be released to:

Names(s)

Family

Other dental offices/laboratories

-----OR-----

I do not wish to have any of my dental related information released to anyone other than myself.

I give permission to leave messages in regard to dental work, results, pre med treatment, outside testing, appointment reminders, etc, on my answering machine or with family member.

-----OR-----

If I am unable to be reached by phone, no phone messages are to be left.

Signature _____

Date _____

*****Any changes of this patient release are to made in writing. NO verbal requests will be honored.

Thank you!!!!