<u>AUTHORIZATION FOR INFORMATION</u>

<u>Important Notice:</u> The law prohibits the release of confidential medical information to an entity without the written voluntary consent of the undersigned patient.

Print Patient Name:____DOB:__________________

- Keizer Family Dental Care may leave messages on my phone Yes No

I authorize Keizer Family Dental Care to confirm appointments and/or discuss information regarding my account, diagnosis, and treatment in detail with: (spouse, relatives, friends, etc.)

___________________________	___________________________	___________________________
Name	Phone	Relationship
___________________________	___________________________	___________________________
Name	Phone	Relationship
___________________________	___________________________	___________________________
Name	Phone	Relationship

If you do not want any information given to anyone other than yourself, please initial here ___________

I understand that you cannot condition provision of services or treatment based on whether or not I sign this authorization. I understand that I have the right to revoke this authorization at any time by providing written notice to this office. I also understand that the revocation is not applicable to information already disclosed while the authorization was in effect. I understand that the information used or disclosed may be subject to redisclosure by the recipient and no longer subject to Federal Law. I understand this document is not a release of medical records.

Signed:____Date:______________

Keizer Family Dental Care
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