Family Dental Care Of Milford, Prof. Assn.
K. Drew Wilson, DMD, MAGD - Joshua T. Osofsky, DMD - Amanda M. Smith, DMD, MPH Ward Gravel, DDS

Consent to Share Confidential Dental Information

To be valid, this form must be filled out COMPLETELY, including what information you are giving us permission to share.

Patient's Legal Name: ______________________________ Birth Date:____________

I HEREBY AUTHORIZE FAMILY DENTAL CARE TO SHARE:

Any of my medical/dental information,
Payment and Insurance Information
My lab results
My appointment times, dates, and reasons for the visits
The medications I am taking
The following information (specify): ____

WITH THE FOLLOWING PEOPLE:

Full Name: ____ Relationship: _________________
Full Name: ____ Relationship: _________________

I understand that I may cancel this consent at any time (by writing to Family Dental Care), but that cancelling it will not affect any information that has already been released.
I understand that I do not have to sign this form, and that I should only sign it if I want my dental provider or my clinic to share my information with someone.
This authorization expires: When I cancel it in writing __________________________________
If no expiration date or event is specified, this authorization will expire one (1) year after the date it is signed.
Signature: ____ Date: ____________________

Relationship to minor patient (if parent or legal guardian):* ____________________________________
If you are not the minor patient's parent, you must give us proof of guardianship (for example, a court order or power of attorney)

Witness: ____ Date: ____________________