<u>Authorization for Release of Information Form</u>

Please list any person that you wish for me to verbally give information to and then whether we can talk to them regarding your Dental/Medical Care, Emergency Issues, or Financial Information

Name:
Date of Birth:
Phone:
What can we contact them about?
Care [ ]
Emergency [ ]
Financial [ ]

Name:
Date of Birth:
Phone:
What can we contact them about?
Care [ ]
Emergency [ ]
Financial [ ]

Name:
Date of Birth:
Phone:
What can we contact them about?
Care [ ]
Emergency [ ]
Financial [ ]

I agree to have messages regarding my appointment left on the phone numbers I have give to Reed City Dental Health Care Associates, P.C. and its employees. I also hereby authorize Reed City Dental Health Care Associates, P.C. and its employees to furnish requested diagnostic services and/or treatment information for the above patient until revoked in writing.

I authorize payment to Reed City Dental Health Care Associates, P.C. of the group insurance benefits otherwise payable to me.

Signature: ____ Date: ________________________