Lux Dental
10 Brook Street
Canandaigua, NY 14424

CONSENT FOR USE & DISCLOSURE OF HEALTH INFORMATION

Patient Name _____

Please choose one:

_____I give permission to the person(s) below to discuss my dental treatment, payment, insurance activities and medical history.

_____ Please do not share my personal information with anyone.

1. Name_____Relationship_____

Address_____

Home Phone_____Work Phone_____Cell Phone_____

2. Name_____Relationship_____

Address_____

Home Phone_____Work Phone_____Cell Phone_____

3. Name_____Relationship_____

Address_____

Home Phone_____Work Phone_____Cell Phone_____

4. Name_____Relationship_____

Address_____

Home Phone_____Work Phone_____Cell Phone_____

_____ _____

Signature Date