Eastern Shore DENTAL CARE
BILLINGS • MURPHY

CONSENT TO DISCLOSE INFORMATION

Patient's name: _____ Date of Birth: ___/____/_____

Information to be used or disclosed:

My Dental Information relating to the following treatment or condition: _____
My entire account information, including payments

Person(s) Authorized to Receive the Disclosure: _____

Authorization and Signature: I authorize the release of my confidential protected dental information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to confirm to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected dental information

Signature of Patient: _____
Date of Signature: ___/____/_____