Patient Confidentiality

PATIENT CONFIDENTIALITY

If you wish others to receive information regarding your care, you must sign this release. By signing this, you are giving the team at our office, permission to release information to others. If you would like us to release information to someone other than insurance companies, specialists, etc. Please list their names /relationship to you and telephone number.

Name	Relationship	Phone #

Patient's First Name *

Patient's Last Name *

Patient's Signature *

Date *

09/06/2023