Indian Valley Dental Associates

601 E. Broad Street • Souderton, PA 18964

215-723-5531

AUTHORIZATION TO DISCLOSE INFORMATION

In the event it becomes necessary: I, _____, hereby authorize Indian Valley Dental Associates to release my patient information, including previous and/or future treatment, to:

Please check and fill out all that apply.

☐ Spouse: _____ Contact Number: _____

☐ Mother: _____ Contact Number: _____

☐ Father: _____ Contact Number: _____

☐ Children: _____ Contact Number: _____

☐ Other: _____ Contact Number: _____

☐ I prefer that my information remain private.

I give my permission to leave messages on an answering machine/voicemail regarding the following:

☐ Scheduling of an appointment

☐ Past, current, or future treatment

X _____ _____

(Patient Signature) (Date)