Dental Associates of Decorah, P.C.

Health Information Verbal Communications Authorization

Patient Name:_________________________ **Date of Birth:**___________________________

The situation may arise that in your best interest, it is necessary to share your specific dental needs with a family member or friend. Please complete the following information.

Verbal Communication Regarding My Treatment Can Be Shared With:

Name:	Relationship:	Phone Number:	Type:
____________ /	____________ /	____________	( ) all ( ) limited to:______
____________ /	____________ /	____________	( ) all ( ) limited to:______
____________ /	____________ /	____________	( ) all ( ) limited to:______
____________ /	____________ /	____________	( ) all ( ) limited to:______
____________ /	____________ /	____________	( ) all ( ) limited to:______

By signing this form and giving permission for us to release information to the above individuals, you understand that at anytime you may change or revoke this authorization.

____ __________________

Signature of Patient **Date**

Confidential