

Preserve Parkway Dental
Disclosure of Information Agreement

Adult children 18 and over, patients with caregivers, or patients who would like spouses to be able to have access to their information should consider filling this out.

This form is optional

I authorize Preserve Parkway Dental to discuss my diagnosis, treatment, scheduling and financial information with the following people:

NAME

RELATIONSHIP

This ***Release of Information*** will remain in effect until terminated by me in writing.

Patient Name: _____

Signature: _____ Date: _____