Dow Dental

Alternate Contact Information and Family/Friends Release of Information Authorization Form

Part I Alternate Contact Information Authorization

PATIENT NAME:

PHONE NUMBER (HOME OR CELL OR OTHER) (CIRCLE ONE):

PATIENT DATE OF BIRTH:

DOW DENTAL HAS MY AUTHORIZATION TO:

Y N leave medical information on my home/cell

Y N contact me at my place of employment

Y N leave medical information on voice mail at my place of employment

Part II Family/Friends Release of Information Authorization

I authorize Dow Dental to discuss **ANY** information regarding my care with below-mentioned persons: (Only list name of persons you are authorizing us to discuss **ANY** information with.)

NAME: RELATIONSHIP

PHONE NUMBER:

NAME: RELATIONSHIP

PHONE NUMBER:

*This authorization is valid until:

*If no date is listed it will expire one year from the date it was signed

Signature and Date of Patient or Legal Representative: