AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name _____ Birth Date mm/dd/yyyy _____

This form is giving authorization for First City Dentistry to release or communicate all of the above patient's pertinent health information, including: insurance, appointments, treatment plans, etc. to the names listed below.

Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship

Signature of Patient (or Legal Representative) **Date**

Relationship to Patient

Electronic Communication Agreement

I give permission for First City Dentistry to communicate with me electronically to:

Confirm appointments by: ☐ **Text** ☐ **Email** ☐ **Call only**

(Please provide if circled)

Cell Phone #: _____ Email: _____

We will use your email if we are unable to reach you via telephone in emergency situations as well as send you our quarterly newsletter.

FIRST CITY DENTISTRY
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