**AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION**

Patient Name d Birth Date d

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

 D d

Name Relationship

 D d

Name Relationship

 D d

Name Relationship

 D d

Name Relationship

 D d

Name Relationship

 D d

Name Relationship

 D d

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

 D

**Relationship to Patient**

**Electronic Communication Agreement**

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

 DConfirm appointments by **Text** **Email**  **Call Only**

**(Please provide if checked)**

Cell Phone #: dEmail: d

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.