



PROGRESSIVE DENTAL, pllc



“Dentistry for All Ages”

Dr. Sonny Spera Dr. Jennifer Redmore Dr. Brian Blanchard
Dr. Matthew L. Franklin Dr. Oreida Quinones Dr. Steve Sheffield

VOLUNTARY

Authorization to Share Information

I authorize the following individual(s):

_____ (Name/Names)

_____ (Relationship to Patient)

To:

_____ receive appointment scheduling/reminders

_____ discuss financial issues on my behalf

_____ pickup copies of my records

_____ prescription pickup

_____ pickup x-ray copies

_____ to bring _____ to the dentist for treatment, including x-rays or fluoride, as needed

_____ discuss treatment options/plan

_____ Date

_____ Patient Name (printed)

_____ Parent/Patient Signature

I understand that I have the right to revoke this authorization at any time

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