

VOLUNTARY
Authorization to Share Information

I authorize the following individual(s):

_____ (Name/Names)

_____ (Relationship to Patient)

To:

 Receive appointment reminders Schedule appointments 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 SoutherTier Health Link **Relationship: _____

(Step-parent, mother-father, health care proxy, power of attorney or legal guardians ONLY)

Date_____
Patient Name (printed)_____
Parent/Patient Signature**I understand that I have the right to revoke this authorization at any time****ENDWELL**565 Hooper Rd.
Endwell, NY 13760
P: 607.754.2273
F: 607.754.9526**NORWICH**101 S. Broad St.
Norwich, NY 13815
P: 607.334.8666
F: 607.334.6662**MONTROSE**57 Public Ave.
Montrose, PA 18801
P: 570.278.1186
F: 570.278.7447**KIRKWOOD**1113 US Rte. 11
Kirkwood, NY 13795
P: 607.722.5464
F: 607.775.1125**BINGHAMTON**51 Front St.
Binghamton, NY 13905
P: 607.724.7166
F: 607.724.7178