progressive dental™

it's personal

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