Horizons Dental Practice

Communication Consent Agreement

This form allows our physicians and office staff permission to speak with your family members other individuals noted below.

I,_____ understand that the Federal Law (HIPPA) this dental office may not release any medical information to any individual without my expressed written permission. Law enforcement and court order are two exceptions to this requirement. I, therefore give permission to Horizons Dental Practice to release dental/medical information on my behalf to the following individual(s).

1. **Name:_____ Relationship:_____**
   Phone Number:_____ Date of Birth:_____

2. **Name:_____ Relationship:_____**
   Phone Number:_____ Date of Birth:_____

3. **Name:_____ Relationship:_____**
   Phone Number:_____ Date of Birth:_____

4. **Name:_____ Relationship:_____**
   Phone Number:_____ Date of Birth:_____

PATIENT NAME:_____ Date of Birth:_____

PATIENT SIGNATURE:_____ Date:_____

If minor Parent's Signature_____ Relationship_____

Parent's/guardian Name_____