Dr. Kevin Norige's

SOUTH WINDSOR

Smiles

Healthy smiles, healthier lives

Consent to Share Information

Patient Name____ D.O.B.____________________

Today's Date_________________

I HEREBY AUTHORIZE DR. KEVIN H. NORIGE'S SOUTH WINDSOR SMILES TO SHARE THE FOLLOWING:

___ Any dental treatment/diagnosis information (including recommended treatment)

___ My appointment times, dates, and reasons for visits

___ The medications I am taking or have been prescribed by this office

___ Insurance information

___ Financial and payment information

WITH THE FOLLOWING PEOPLE:

Full Name ____________________________________ Relationship__________________

Full Name ____________________________________ Relationship__________________

Full Name ____________________________________ Relationship__________________

I understand that I may cancel this consent at any time, but that cancelling it will not affect any information that has already been released.

I understand that I do not have to sign this form, and that I should only sign it if I want my dental provider to share my information with someone.

I will contact the office if there are any changes that I would like to make to this consent.

Signature ____ Date _____________________