Authorization of Release of Information

I give authorization to Riverside Dental to speak to _____ regarding the following (please check all that apply):

___ All past, current and future dental care including treatment plans and treatment options as well as scheduled appointments.

____ All Financial matters relating to my account.

____ _____

_____

I understand that I may alter or cancel this authorization at any time and will notify Riverside Dental immediately if I wish to make any changes to this authorization. This authorization will remain in effect for one year from date of signature.

_____

_____

Print name Date

_____

Sign name