Abbett & Associates
Family and Cosmetic Dentistry

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Medical Information Release

Due to federal guidelines, we are requesting patient signatures to designate specific types of contact for disclosing protected medical, financial and insurance information.

Please ***INITIAL*** the appropriate box or boxes if you are authorizing us to leave protected health information.

If you check "***MYSELF ONLY***" you may ***NOT*** check any other option.

- ☐ On Home answering machine
- ☐ On Work answering machine
- ☐ With a family member (please print their name and relation below)

- ☐ With a caretaker
- ☐ On cell phone voice mail
- ☐ With significant other
- ☐ Myself only
- ☐ Other _____

Printed Name _____

Signature _____ Date ____ /____ /____

This authorization may be revoked at any time upon request.