SCHIMP
FAMILY DENTISTRY

Patient Name: _____ **Date of Birth:** _____

AUTHORIZATION TO SHARE DENTAL INFORMATION

I authorize Schimp Family Dentistry to share my:

- Billing/financial information
- Information regarding appointments/scheduling
- Insurance information/pre-determinations of insurance benefits
- All information

With the following individuals:

Name: _____ Relationship to Me: _____

Name: _____ Relationship to Me: _____

Name: _____ Relationship to Me: _____

Name: _____ Relationship to Me: _____

-OR-

- I do NOT authorize Schimp Family Dentistry to release any of my dental information to anyone, with the exception of coordination of benefits (i.e., insurance) or continuation of care (i.e., referrals).

This authorization will remain in effect until revoked in writing by the above listed patient.

Patient Signature: _____ Date: _____