MILLHOPPER
FAMILY DENTISTRY

I, _____ will allow the following people to be able to obtain or discuss any of my dental information. This includes my dental records, treatment, and financial responsibilities. If I wish to make a change to this form, I will contact Millhopper Family Dentistry and complete an updated form to be kept on file.

_____
Name / DOB / Relationship to Patient

_____
Name / DOB / Relationship to Patient

_____
Patient Signature/Date

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