NORTH OAKLAND DENTAL GROUP
RELEASE FORM/ EMERGENCY CONTACT

PATIENT NAME_____D.O.B_____

I authorize my protected health information to be released to the following:

NAME_____

RELATIONSHIP _____
(spouse, parent etc.)

NAME_____

RELATIONSHIP _____

NAME OF EMERGENCY CONTACT_____

HOME#_____CELL #_____

I understand this release of Information form will remain in effect until terminated by me in writing. All patients over 18 must sign their own forms. Only a parent or legal guardian may sign for a patient under the age of 18.

Signature_____ Date_____

Print name of Parent or Legal Guardian_____