Family Dentistry of Columbus

3408 University Ave. Suite B
Columbus, GA 31907
Ph: 706-563-5516

Authorization to Release & Discuss Dental Information

Please provide all family members or friends you want us to be able to speak with about your dental treatment and care. You may opt out by checking the "Do not release information" line below.

I give the following named person(s) authorization to speak with the office of Family Dentistry of Columbus, on my behalf, regarding (please check all items authorized):

Name of authorized person: ________________________________Relationship: ____________________
Phone number: _________________________________
___ Appointments ___ Financial ___ Dental Treatment ___ Insurance

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___ Do NOT release information to anyone

With my signature below, I acknowledge and understand that this information will be kept in my dental record and the above parameters will remain in effect until revoked by me in writing. It is my responsibility to notify my healthcare provider should I wish to change one or more contacts listed above.

Patient's name: ________________________________ Date of Birth: ______________________
Please Print Name

____ Date: _____________________________
Signature of patient or patient's authorized representative