Hoye Dental

www.hoyedental.com

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Authorization to Disclose Form

I ______________________________ (print patient name), authorize the person(s) listed below to discuss any services, treatments, payments and all aspects of my dental care with Hoye Dental while a patient of Hoye Dental.

Person(s) to disclose information to:

1.________________________________ (print) ______________________________ (sign)

2.________________________________ (print) ______________________________ (sign)

3.________________________________ (print) ______________________________ (sign)

Patient Signature: ____**Date**:______________