Healthy Smile Dental, PC
1920 87th St., Suite B
Woodridge, Il 60517

DISCLOSURE OF INFORMATION

I give Healthy Smile Dental full permission to discuss my dental records with the individuals that I have designated below for the purpose of disclosing detailed information pertinent to my care. This would include, but not be limited to information regarding radiographs, treatment plans, billing, scheduling, and business information. By my signature below, I agree to hold harmless and waive any liability against Healthy Smile Dental for the disclosure of information to me and/or the individual(s) designated below.

_____

Full Name *Relationship to Patient* *Phone Number*

_____

Full Name *Relationship to Patient* *Phone Number*

If you **do not** wish Healthy Smile Dental to discuss your dental information with anyone except you, please write **NONE** on the line below.

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Patient Signature *Date*