SOUTHWEST DENTAL GROUP
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PERMISSION TO DISCUSS MEDICAL INFORMATION

All medical/dental records are confidential. We require written authorization to release medical information to anyone other than the patient. **By signing the authorization below, you are giving us permission to discuss the information contacted in your medical/dental information with another individual.**

I, _____, give Dr. Robert Schick and staff of Southwest Dental Group permission to discuss my diagnosis, procedures and/or treatment plan including fees with.

Please list name(s)

Signature_____ Date_____

Printed name_____