SHARING INFORMATION WITH FAMILY/FRIENDS

I give permission to Schara Dentistry to verbally discuss my dental/medical information (including appointment schedules, symptoms, diagnosis, medications, treatment options, etc.) or payment information with the following individuals involved in my care.
*This does not allow these individuals to obtain dental records.

Name ______________________________________ Relationship
____

Name ______________________________________ Relationship
____

Patient Name ____

Patient Signature ____ Date ____________________