

Patient / Spouse Release Form

In order to protect your personal information, we will NOT give information about your treatment to non-medical personnel without your permission. We will therefore be asking you to sign a release for us to share your information with persons who may be an exception. This exception may include your spouse or another family member.

Many people DO want their spouse or another family member to have information about their condition. If you agree that your spouse or family member(s) may have such information, please sign below and return this form to us.

I, _____, give my permission for my spouse or family member to know information about my dental treatment.

The person who may have access to this information is:

_____	Relationship to you: _____
(Person's name)	
_____	Relationship to you: _____
(Person's name)	
_____	Relationship to you: _____
(Person's name)	

_____	_____
(Patient's Signature)	(Date)