

Dr. Nicholas Bowman D.M.D.

Southeastern Dental Associates of Soddy Daisy

Permission For Verbal Communications

(Name of Patient)

(Birth Date)

(Street Address)

(City, State, Zip Code)

(Phone Number)

I permit Dr. Nicholas Bowman D.M.D., and other personnel to discuss dental / health information, in person or by telephone, with the following family members or friends involved in my medical/ dental care:

This authorization is limited to discussions regarding the following dental / medical condition(s):

(If no limitations are listed, discussions will be permitted regarding any dental/ medical condition for which the patient has received care.)

Name

Phone Number

Relationship

1- _____

2- _____

Release of information under this document is limited to verbal discussions with my Health Care Providers. This document does not permit release of any written dental/ health information to the individuals named above.

This authorization is limited to the following timeframe from _____ (date) to _____ (date)

If no dates are indicated, this form will remain in effect for an unlimited amount of time.

If, at any time, I do not want verbal discussions to be permitted between my Health Care Providers and any of the individuals named above, I must notify my Health Care Provider by contacting the office of Dr. Nicholas Bowman D.M.D.

Patient's Signature: _____ *Date:* _____

If this Release is signed by a representative on behalf of the patient, complete the following:

Representative's Name: _____

Relationship to Patient: _____

INSTRUCTIONS: Please print, sign and send to: Dr. Nicholas Bowman D.M.D.

124 Harrison Lane, Suite 100

Soddy Daisy, TN 37379

Phone: (423)332-0500

Fax: (423) 332-0920

Email: officesd@volstate.net