

Oak Park Dental

3380 Astoria Way NE
Salem, OR 97305
Phone# 503-588-7800
Fax # 503-391-0762

CONSENT TO SHARE DENTAL INFORMATION

Patient Name: _____ Date of Birth: _____

I HEREBY AUTHORIZE OAK PARK DENTAL TO SHARE: (Please check all that may apply)

- Treatment plan information (such as treatment needs and details about oral health condition)
- Medications I am taking
- Billing Information
- Appointment Dates/Times and reasons for the visits

WITH THE FOLLOWING PEOPLE:

Full Name: _____ Relationship: _____

Full Name: _____ Relationship: _____

Full Name: _____ Relationship: _____

- I do **not** want Oak Park to share any of my health/dental information with anyone.

I understand that I may cancel this consent at any time, but that cancelling it will not affect any information that has already been released.

- I consent Oak Park Dental to leave detailed messages regarding my appointments, treatment needs and medications at the phone number/s listed below.

Phone # _____ Phone # _____

Patient Signature: _____ Date: _____