

**BELLEAIR ORAL SURGERY & IMPLANTS**  
**PERMISSION TO DISCUSS**

Patient Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_

\_\_\_\_\_ Yes \_\_\_\_\_ No      May we e-mail you with your personal health information if requested by you?

If yes, provide us with you e-mail address: \_\_\_\_\_

\_\_\_\_\_ Yes \_\_\_\_\_ No      May we e-mail/fax or discuss your person health information to/with other physicians participating in your care such as your general dentist, primary care physician, or a specialists

Please list the names of any Friends/Family that we may discuss your private health information with (Example: Treatment performed, Financials)

	Name	Relationship to Patient	Contact Number
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

By signing this form, I hereby grant permission to the staff of Belleair Oral Surgery & Implants to discuss information related to my care with the individuals listed above (This release includes all physicians that are an active part of my care.) **This Release of information will remain in effect until terminated by me in writing.**

Signature: \_\_\_\_\_

(Patients that are 18 years and older must sign this form. The signature of a parent, guardian or spouse is not acceptable.)

Relationship to patient: \_\_\_\_\_ Date: \_\_\_\_\_