Enlow & Vance Dental Partners, P.A.

"Your partners for dental fitness"

Authorization for Release of Identifying Health Information & Payment Disclaimer

Date: ______________________________

Patient's Name: ______________________________

Patient's Date of Birth: ______________________________

I accept full responsibility for fees incurred for treatment rendered to me by Enlow & Vance Dental Partners, their doctors and their staff.

I authorize the release of any information required to referring dental professionals or to complete my insurance claims and further authorize payment directly to Enlow & Vance Dental Partners. I authorize the release or discussion of my treatment or any information pertaining to my records or treatment to the physician(s) listed below. I also authorize the use of photos and x-rays of my treatment, both before and after, for promotional and training purposes. A copy of this authorization may be used in place of the original.

Authorized Physician(s) Name & Contact Information ______________________________

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In addition to the physician listed above, I also authorize the additional following person(s) to discuss and/or schedule treatment or payment on my behalf (it is not assumed that your spouse is an authorized person unless listed below):

Additional Authorized Person(s) ______________________________

Signed: ______________________________ Date: ____________________
Patient

Signed: ______________________________ Date: ____________________
Guardian, if assigned to patient,
or if patient is under 18 years old

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