Consent for Contact Preferences and Release of Clinical Findings to Dental Practitioner and Medical Doctor

Patient _____ Date _____

How would you like for our office to contact you regarding appointment confirmations, test results, and questions?
(Please check all that apply, and list the information for that selection)

_____ Email _____ _____ Phone # _____

_____ US Mail _____ _____ Text # _____

_____

Who would you like for us to send your clinical narrative to: (Check one of the following)

_____ **Yes**, I give my permission to the Gelb Rejuvenation Center to send a copy of the clinical narrative, digital photos, and CT scan to the following doctors:

General Dentist: _____

_____

_____

Medical Doctor: _____

_____

_____

Other: _____

_____

_____ **No**, I do not give my permission to the Gelb Rejuvenation Center to send a copy of the clinical narrative, digital photos, and CT scan to my doctors.

_____ _____

Patient Signature Date

_____ _____

Staff Signature Date