



## Consent for Disclosure of Healthcare Information

Patient \_\_\_\_\_

I give Capitol Hill Dental and staff permission to speak with the person(s) listed below regarding my dental health care, diagnosis, treatment and payments for services rendered.

Name \_\_\_\_\_ Phone # \_\_\_\_\_

Name \_\_\_\_\_ Phone # \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

This consent is valid until I provide a written revocation of it