MedArt Endodontics, LLC

Communication Consent

It is the office policy of MedArt Endodontics, LLC and staff not to release confidential and/or unauthorized information without patient consent. Information will not be left with an unauthorized person who may answer the telephone.

I authorize MedArt Endodontics, LLC and/or their staff to leave medical/dental information pertaining to my care in the following methods, and I will assume responsibility to notify them whenever this information changes.

Patient Name: _____
*(*Please print clearly*)*

Date of Birth: _____ **Today's Date**: _____

I give permission to leave my medical/dental information at the following telephone number(s) with the following person/people. (Please print clearly)

Number	**Home**
Number	**Cellular**
Number	**Work**
Name	**Relationship**
Name	**Relationship**
Name	**Relationship**

Signature of Patient, Parent or Legal Guardian

_____ _____

(Please Sign) (Please print clearly)