Tucker & Gailis Dental
2586 Clover St, Klamath Falls, Or 97601
541-884-9555 Fax# 541-882-7423

Authorization to Discuss Confidential Patient Information

I_____, hereby authorize the doctors and staff of this office to release and/or discuss any and all information pertaining to my health care, test results, procedures, billing and/or accounting information to the following person(s) or agencies,

Relationship ___None Name:_____
___Spouse DOB:_____
___Parents
___Other

I further authorize the doctors and their staff to dispense results from my dental exams, or treatment in one or more of the following ways, please check all that apply:

We may leave a message during business hours:
___ On answering machine at home
___ Voicemail at work
___ Cell phone
___ Other_____

I understand that this office will release any information to those persons whom I have determined may receive this information without separate consent. In addition, I understand that this relates to all dental as well as billing information. This will be actively enforced. If you wish to change the status of this form, you must do so in writing.

_____ Date_____
Patient Signature

***** THIS AUTHORIZATION IS TO REMAIN IN EFFECT UNLESS REVOKED IN WRITING BY THE PATIENT*****