TRIPLE CITIES
FAMILY DENTAL, P.C.

## RELEASE OF DENTAL/MEDICAL INFORMATION TO FAMILY MEMBERS

I hereby give my consent for this office to release my medical information to the following person(s):

| Name | Relationship |
| --- | --- |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

I do not hold this office responsible for releasing this information.

This release will remain in effect until this office receives written notice to the contrary.

Signature of Patient: _____

Date Signed: _____

Patient's Name: _____
(Please print)

Date of Birth: _____

David Salomons, D.D.S.

Adam Underwood, D.D.S.

18 Leroy Street, Binghamton, NY 13905
607-723-8377

TripleCitiesFamilyDental.com