INFORMATION RELEASE CONSENT FORM

MADISON FAMILY DENTAL
502 NE 2nd St, Madison, SD 57042
Phone (605) 256-2670 FAX (605) 256-3172
madisonfamdental@gmail.com

PLEASE SELECT ONE OPTION

☐ I prefer to have a ***separate account*** and **NOT SHARE** information about dental care/billing.

☐ I prefer to have a ***separate account*** but information about my dental care/billing can be **SHARED** with the following (completely fill out portion below):

☐ I prefer to have a ***linked account*** with my spouse/family so information can be acquired and **SHARED** easily (completely fill out portion below):

*18YRS OR OLDER CAN NOT BE LINKED WITH PARENTS

FILL OUT COMPLETELY IF YOU WANT ACCOUNTS LINKED OR SHARED

I, _____ authorize Madison Family Dental to provide:
(patient) **(PLEASE COMPLETE ONE LINE (SECOND LINE, IF NEEDED))**

_____	_____	_____	_____
(print name of spouse, parent, etc.)	**(DOB)**	**(phone number)**	**(relationship)**

_____	_____	_____	_____
(print name of spouse, parent, etc.)	**(DOB)**	**(phone number)**	**(relationship)**

with information in regards to any dental care and billing (e.g. appointments, treatment plans/estimates, insurance and statements).

I understand that the specific type of information to be disclosed includes a detailed report of examinations, findings, treatments, prognosis and copies of any and all other records, including pertinent radiographs, digital images or intraoral photographs which pertain to me.

This consent is effective until I cancel it and understand that the information obtained as a result of this consent (e.g. diagnosis) may be used after the cancellation date.

Patient's Signature _____ **Date** _____