



1201 S Elk Street
Casper, WY 82601
Phone: (307) 234-3890
Fax: (307) 472-5583

Permission to Share Medical Information

Patient's Legal Name: _____

Birth Date: _____

I HEREBY AUTHORIZE SIGNATURE DENTAL TO SHARE:

- Any of my medical dental information, including information about
- X-rays
- Appointment times, dates, and reasons for the visits
- Medication I am taking
- The following information (specify):

With the following people:

Full name: _____

Relationship: _____

Full name: _____

Relationship: _____

I understand that I may cancel this consent at any time, but cancelling it will not affect any information that has already been released.

Printed name: _____

Signature: _____

Date: _____

Relationship to minor patient (if parent or legal guardian): _____

If you are not the minor patient's parent, you must give us proof of guardianship (for example a court order or power of attorney)

Witness: _____

Date: _____