NASHUA FAMILY DENTISTRY
25 Riverside St., Ste. 201
Nashua, NH 03062
(603)882-2575
Fax: (603)546-0755

CONSENT TO SHARE CONFIDENTIAL MEDICAL/DENTAL INFORMATION

To be valid, this form must be filled out COMPLETELY, including what information you are giving us permission to share.

Patient's Legal Name: _____

Date of Birth: _____

I HEREBY AUTHORIZE NASHUA FAMILY DENTISTRY TO SHARE:

☐ Any of my dental information **including information about:**

- ◇ Dental treatment received / required

☐ My financial standing **including information about:**

- ◇ Balances/credits on my account
- ◇ Insurance carrier, payments made by insurance, outstanding claims to insurance
- ◇ Payment plans both in house and/or with care credit

☐ My appointment times, dates, and reasons for the visits

☐ Medications I am taking

☐ The following information (specify): _____

WITH THE FOLLOWING PEOPLE:

Full Name: _____ Relationship: _____
Full Name: _____ Relationship: _____
Full Name: _____ Relationship: _____
Full Name: _____ Relationship: _____

I understand that I may cancel this consent at any time (by writing to Nashua Family Dentistry), but that cancelling it will not affect any information that has already been released.

I understand that I do not have to sign this form, and that I should only sign it if I want my dental provider or my clinic to share my information with someone.

This authorization expires ☐ when I cancel it in writing ☐ _____.
If no expiration date or event is specified, this authorization will not expire.

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: _____