VER: 2/2014

To Whom It May Concern,

I _____ authorize Bayview Dental to release any information regarding my dental health to the following:

_____	_____	_____
Name	Relation	Phone Number
_____	_____	_____
Name	Relation	Phone Number
_____	_____	_____
Name	Relation	Phone Number
_____	_____	_____
Name	Relation	Phone Number

Thank you,

_____
Patient Signature

_____ _____
Patient Printed Name Date