Date: [ ]

Glenmont Dental
336 Glenmont Road
Glenmont, NY 12077
(518)472-8064

Information release

I : [ ]

Hereby give permission to : [ ]

To see and discuss my: ☐ Records ☐ Chart ☐ Finances ☐ Treatment

with the doctor/staff when needed.

Office staff may leave messages confirming or regarding my treatment and recare visits at: ☐ Home ☐ Work ☐ Cellphone ☐ E-mail

☐ I DO NOT WANT any of my information released. This information will not be release unless i presonally request the change. (Patient can change their mind at any point in time, however an office personal must be informed of the change.)

Patient name and signature: [ ]

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Witness name and signature: [ ]

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