Dr. Joseph S. Whitehead
Dr. Karma L. Weeden
Dr. Elizabeth Earle

DENTAL INFORMATION RELEASE FORM

Name: _____ **Date of Birth:** _____/_____/_____

RELEASE OF INFORMATION

I authorize the release of information including diagnosis, records, and examination records; examinations rendered to me and claims information. This information may be released to:

_____ _____
(Name) (Relationship)

_____ _____
(Name) (Relationship)

_____ _____
(Name) (Relationship)

This ***Release of Information*** will remain in effect until terminated by me in writing.

MESSAGES

Please call [ ] home [ ] work, and/or [ ] cell number: _____

If unable to reach me:
- [ ] you may leave a detailed message
- [ ] please leave a message asking me to return your call
- [ ] _____

The best time to reach me is *(day)* _____ between *(time)* _____

Signed: _____ **Date:** _____/_____/_____

196 S. McCleary Road
Excelsior Springs, MO 64024
(816) 630-5713