Crofton Dental Suites
2191 Defense Highway, Ste. 210
Crofton MD 21114
(410)721-2610 email: croftondentalsuite@gmail.com

DISCLOSURE TO OTHERS

(This form pertains only to your medical/dental information)

____ ____/____/____
Patient Name (Print) DOB

_______ **I DO NOT AUTHORIZE Crofton Dental Suites ("Provider")** to disclose any information concerning my **Care** or **Treatment** by Provider to individuals without my express written consent or legal authorization.

_______ **I AUTHORIZE ("Provider")** to disclose information related to my **Care** and **Treatment** to the following named individual(s):

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

This will remain in effect until I rescind it in writing.

______________________________________ ________________
Signature of Patient (or legally responsible individual) Date

______________________________________ ________________
Witness Date