SOUTHWEST ORAL SURGERY

DAVID A. DURHAM, D.M.D. **GREGG W. HOSCH, D.D.S.**
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CONSENT TO RELEASE INFORMATION

Patient:_____ Date of Birth:_____

Please circle your answer to each statement:

YES/ NO You may leave a message on my answering machine at my home.

YES/ NO You may leave a message on my voicemail at my work.

I understand that it is my responsibility to provide authorization to Southwest Oral Surgery, Inc in order to release any medical information regarding my care. I hereby authorize Southwest Oral Surgery, Inc to release medical information to the following:

_____(Spouse) _____(Significant Other)

_____(Parent) _____(Parent)

_____(Sibling) _____(Child)

_____(Friend) _____(Friend)

_____(Employer) _____(Other)

By signing this release, I am authorizing any employee of Southwest Oral Surgery, Inc. to either provide verbal or written information regarding my medical condition to the above named individual(s). This authorization may be cancelled by me at any time upon written notification

_____ _____

Patient Signature Date