

PREMIERE DENTISTRY OF TAHLEQUAH

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AUTHORIZATION TO DISCUSS PATIENT TREATMENT

Patient Name: _____ DOB: _____

I consent for the office of Premiere Dentistry of Tahlequah to share my personal information with the following: (family, friends, etc.)

Name:	Relationship:
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____

This authorization applies to all medical/dental treatment and/or treatment cost.

Patient or Parent/Guardian Signature: _____

Date: _____