Dennis J. Perrott, D.D.S.

Practice Limited to Periodontics
211 Prime Point, Suite B
Peachtree City, Georgia 30269

(770) 487-1978 FAX: (770) 487-9142

______________________________ ______________________________
Patient Name Date of Birth

______________________________ ______________________________
Street Address City, State, Zip

I authorize Dr. Dennis Perrott, DDS and staff to discuss dental / health information in person, or by telephone, with the following family members or friends involved in my care: (List family members/friends and state the person's relationship to the patient).

This authorization is limited to discussions regarding the following dental/medical conditions:
____.
(If no limitations are listed, discussions will be permitted regarding any medical/dental condition for which the patient has received care.)

Name	**Phone Number**	**Relationship**
1. __________________________	___________________________	________________________________
2 ___________________________	___________________________	_______________________________

Release of information under this document is limited to verbal discussions with my health/ dental providers. This document does not permit release of any written health/dental information to the individual's named above.

This authorization is limited to the following timeframe from _______________ to _______________. If no dates are indicated, this form will remain in effect for an unlimited amount of time.

If at any time, I do not want verbal discussions to be permitted between my health/dental care providers and any of the individuals listed above, I must notify my health care provider by contacting the office at 770-487-1978.

Patient / Guardian signature: _______________________________________ Date: _________________________________

If this Release is signed by a representative on behalf of the patient, complete the following:

Representative's Name: ____ Date: _________________________________

Relationship to Patient: ____ Date: _________________________________