Dr. Michael Kokolis D.D.S
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PERMISSION TO DISCLOSE TREATMENT FORM

Date:_____

I, _____ authorize Bell Dental Care to disclose my future and current dental treatment with:

_____

(relationship) _____.

I, _____ authorize the release of the following information (check all that apply).

☐ All of my dental information that the provider has in his/her possession, inlcuding information regarding any future dental treatment I may need.

☐ Only the following dental records (Please specify):

_____

Signature of patient: _____ Date:_____

If individual is unable to sign this authorization, please complete the information below:

Name of gaurdian: _____

Date: _____ Relationship:_____