Coastal Dental Associates
118 Alden Road
Fairhaven, MA 02719
(508)994-2255

Consent For Disclosure of Health Care Information

Patient Name: _____ (Last) _____ (First) ____ (MI) _____ (Preferred Name)

I give Coastal Dental and staff permission to speak with the person (s) listed below regarding my dental and health care, including diagnosis, treatment, and payment for services rendered:

Name Phone # Cell #

_____

Name Phone # Cell #

_____

In addition to sending postcards, I give Coastal Dental and staff permission to provide appointment reminders using: (Check all that apply)

☐ Voicemail ☐ Answering Machine ☐ Texting

☐ Email _____ ☐ Cell Phone #_____

Best Telephone No. to contact me is

_____

Emergency Contact: (Name, Phone #, Cell #.)

_____

Signature: _____ Date: _____

This Consent is valid until such time as I provide a written revocation of it.

Response Date: _____