Signature Dental

Paul A. Dona, DDS
1201 S. Elk Street
Casper, WY 82601
Phone: (307)234-3890 Fax: (307)472-5583

Permission To Share Medical Information

Patient's Legal Name:
_____

Birth Date:_____
I HEREBY AUTHORIZE Dr Paul A. Dona, DDS TO SHARE:

- ☐ **Any of my medical/dental information, including information about:**
- ☐ **⃠ ▤ ⑨ ☙ ❺ ⑩**
- ☐ **My appointment times, dates, and reasons for the visits**
- ☐ **The medications I am taking**
- ☐ **The following information (specify):**

_____

WITH THE FOLLOWING PEOPLE:
Full Name: _____
Relationship: _____
Full Name: _____
Relationship: _____
Full Name: _____
Relationship: _____
Full Name: _____
Relationship: _____

I understand that I may cancel this consent at any time, but that cancelling it will not affect any information that has already been released.

Printed Name:_____
Signature: _____
Date: _____

Relationship to minor patient (if parent or legal guardian)*:
_____

If you are not the minor patient's parent, you must give us proof of guardianship (for example, a court order or power of attorney)

Witness: _____
Date: _____