

# Release of Information

I, \_\_\_\_\_, hereby give my permission for the office of  
McCarley Restorative & Cosmetic Family Dentistry to release my personal  
information to the following:

*(Please list anyone and everyone that you would like your information released to. If this form is not  
completed, no information will be shared with anyone other than yourself and your appropriate insurance  
company.)*

_____	_____
_____	_____
_____	_____
_____	_____

***This information is including, but not limited to: insurance benefits,  
necessary and/or completed treatment, account balances and appointment  
date/time(s).***

I give permission for the above listed person(s) to access personal  
information on my account with McCarley Restorative & Cosmetic Family  
Dentistry.

Patient (printed)Name

Patient Signature

Date

I DO NOT GIVE PERMISSON TO RELEASE ANY INFORMATION.  
Please do not release my information with anyone other than myself and/or  
my insurance company.

Patient (printed)Name

Patient Signature

Date