ibeliv
DENTAL STUDIO
Aesthetic & Wellness Family Dentistry

Consent to Share Confidential Medical/Dental Information

Patient's Legal name: _____

Birth Date: _____

I HEREBY AUTHORIZE *iBELiV DENTAL STUDIO* TO SHARE:

- Any of my medical/dental information, including information about:
  - Diagnosis
  - Recommended Treatment
  - X-rays
  - Clinical Records
- My Lab Results
- 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 (by writing to *iBeliv Dental Studio*), but that canceling it will not affect any information that has already been released.

I understand that I do not have to sign this form, and that I should only sign it if I want my medical/dental provider or my clinic to share my information with someone.

Signature: _____ Date: _____

Relationship to minor patient (if parent or legal guardian)*: _____
If you are not the minor patient's parent, you must provide proof of guardianship (ie, a court order or power of attorney)

Witness: _____ Date: _____

7700 Lake Wilson Rd. • Davenport, FL 33896
phone: 863.420.3166 • *fax:* 863.420.3866 • *email:* dentist@ibelivdentalstudio.com
www.ibelivdentalstudio.com