

FINGERLAKES ENDODONTICS

Practice Limited to Endodontics

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I hereby authorize the release of information regarding any treatment, appointments, and account information to the following:

1. Name: _____ Phone: (____) _____ - _____

2. Name: _____ Phone: (____) _____ - _____

3. Name: _____ Phone: (____) _____ - _____

4. Name: _____ Phone: (____) _____ - _____

Signed: _____

Date: ____/____/____

(Patient, Parent/ Guardian)

I hereby authorize FingerLakes Endodontics to leave phone/cell messages regarding my appointments, insurance and account information.

Signed: _____

Date: ____/____/____

(Patient, Parent/ Guardian)