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)