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: This would be in reference to a family member or close friendship. Dental and Healthcare providers are excluded.

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)