Lehigh Valley Endodontics-Bethlehem, PC
Communication Consent

It is the office policy of Lehigh Valley Endodontics-Bethlehem, PC and staff not to release confidential and/or unauthorized information without patient consent. Information will not be left with an unauthorized person who may answer the phone.

I authorize Lehigh Valley Endodontics-Bethlehem, PC and/or their staff to leave medical/dental information pertaining to my care in the following methods, and I will assume responsibility to notify them whenever this information changes.

Patient Name: _____
(*Please print clearly*)
Date of Birth: _____ Today's Date: _____

I give my permission to leave my medical/dental information at the following telephone number(s). (*Please print clearly*)

_____
Number Home

_____
Number Cellular

_____
Number Work

I give permission to leave my medical/dental information with the following individuals. (*Please print clearly*)

_____
Name Relationship

_____
Name Relationship

_____
Name Relationship

Signature of Patient, Parent or Legal Guardian

_____ _____
(*Please Sign*) (*Please print clearly*)