CONSENT OF SHARING TREATMENT INFORMATION

I_____ authorize the office of Dr. William L. Gardner, DDS to explain or share my dental treatment or discuss my dental history information to the person(s) designated (_____) Relationship to patient ; (_____) for better knowledge of what is to be done or has been done.

Patient's Name:_____Date:_____

Authorized by (Patients signature)
Name;_____Date:_____

Phone Number:_____

Thank you.