newleaf
family dental

I do hereby grant permission for New Leaf Family Dental, to disclose my personal health information to the following personal representative(s): (spouse, sibling, parent, child, friend, etc.)

NAME	RELATION
NAME	RELATION
NAME	RELATION
NAME	RELATION
NAME	RELATION

Information to be disclosed (please check)

- ☐ Appointment Dates and Times
- ☐ Treatment Plans and Referrals
- ☐ Financial and Billing Information
- ☐ Any other pertinent dental health information related to treatment at this office
- ☐ All of the Above
- ☐ Please do not disclose any information to the above parties

PRINT PATIENT NAME _____ DATE _____

SIGNATURE _____

newleaf family dental

314 West Main St
Cheshire, CT 06410

PHONE 203-250-3446
FAX 203-250-0193
EMAIL info@newleaffamilydental.com
WEB SITE www.newleaffamilydental.com