Authorization to Release Confidential Information

Please answer YES or NO to the following questions.

_____ Do you wish the office of Dr. Dominguez to release records to a named treating doctor? If no, the patient will be responsible for taking any pertinent records to that Doctor. If lost or destroyed; there may be a charge for duplication of the x-rays and/or records.

_____ Do you wish for the office of Dr. Dominguez to disclose records and/or information to a spouse, guardian, caregiver, or any other named person? If yes, please indicate the person(s) or entity:

_____

Authorization to Release Confidential Information – Phone Calls

The office of Dr. Dominguez may need to contact you by phone to discuss information or appointments related to your treatment in the office.

Please indicate the phone numbers where we may contact you.

Home: ☐ Leave detailed message ☐ Leave call back # only

Cell: ☐ Leave detailed message ☐ Leave call back # only

Work: ☐ Leave detailed message ☐ Leave call back # only

Authorization to Receive Electronic Communication (Email)

I agree that the dental practice may communicate with me electronically at the email address below. **I am aware that there is some level of risk that third parties might be able to read unencrypted emails.**

I am responsible for providing the dental practice any updates to my email address.

I can withdraw my consent to electronic communications by calling: **281-280-9149**.

Email Address (PLEASE PRINT CLEARLY):
_____@_____

I have read the above consents and I authorize any and/or all of the above information releasable by David Dominguez, DDS and Mauricio Rodriguez, DDS. I have also been given the opportunity to read the office's Notice of Privacy Practices. These consents are effective until such date which will be given in writing. I understand that information obtained as a result of this consent will be used only for the purpose it is intended. A photo static copy is available upon request.

_____

Patient (Guarantor if minor) Signature Date