WEST RIVER DENTAL

FAMILY & COSMETIC

JOHN R. JORDAN D.D.S.

1106 WEST RIVER ROAD
DETROIT LAKES, MN. 56501
(218) 846-1900

PERMISSION FOR COMMUNICATIONS

Name of Patient:_____ Patient Date of Birth:_____

I permit West River Dental, its doctors, hygienists, dental assistants, and other personnel (Health Care Providers) to discuss health information, in person, telephone, or other correspondence, with the following family members or friends involved in my medical care: (List family members/friends and state the person's relationship to the patient.)

Name:	Phone Number:	Relationship:
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____

If at any time, I do not want discussions to be permitted between my Health Care Providers and any of the individuals named above, I must notify West River Dental.

Patient's Signature: _____ Date: _____

If this release is signed by a representative on behalf of the patient, complete the following:

Representative's Name: _____

Relationship to Patient: _____

SMILES@WESTRIVERDENTAL.COM

FAX: (218) 847-5079