BELLEVILLE SLEEP DENTISTRY
Dr. Michael Chow, Board Certified Dentist-Anaesthesiologist
222 Bell Blvd., unit 6, Belleville, ON K8P 5L7
☎ 613-962-7773 613-962-7778 ✉ bellevillesleepdentistry@hotmail.com

AUTHORIZATION TO RELEASE AND DISCUSS PATIENT INFORMATION

Patient Name: _____ Date of Birth _____

Our privacy policies require that we only communicate with patients themselves, parents, court appointed guardians, insurance providers and primary care dentists/physicians, unless we have authorization in writing by the patient/ legal guardian to communicate with others on their behalf.
Please provide all family members or friends you want us to be able to speak with. Spouses are not automatically included; their names must be explicitly stated below. You may opt out by checking the "Do not Release Information" box below.
Please note that this authorization does not entitle a grandparent, personal care provider, another family member or friend to authorize treatment on your behalf. As a result, a custodial parent or court appointed legal guardian must accompany patients under the age of 18 or dependent adults for the full duration of the sedation appointment - please contact our office to discuss alternatives if for any reason that is not possible. Failure to do so may result in the appointment being cancelled and a fee consistent with our No Show policy being charged.

AUTHORIZATION TO SPEAK WITH FAMILY/FRIEND (INCLUDING SPOUSE)

I give the following named person(s) authorization to take messages or speak with the office of Dr. Michael Chow, on my behalf regarding the abovenamed patient (please check all items authorized).

Name of authorized person: _____ Relationship: _____ Phone: _____
☐ Medical history ☐ Dental Treatment ☐ Appointments ☐ Financial /Insurance ☐ Other:_____

Name of authorized person: _____ Relationship: _____ Phone: _____
☐ Medical history ☐ Dental Treatment ☐ Appointments ☐ Financial /Insurance ☐ Other:_____

Name of authorized person: _____ Relationship: _____ Phone: _____
☐ Medical history ☐ Dental Treatment ☐ Appointments ☐ Financial /Insurance ☐ Other:_____

☐ *DO NOT RELEASE INFORMATION TO ANYONE*

I understand that my express consent is required to release any dental/health care/financial information. With my signature below, I acknowledge and understand that this information will be kept in my dental/medical record and the above parameters will remain in effect until revoked by me in writing. It is my responsibility to notify my dental/healthcare provider(s) should I wish to change one or more contacts listed above.

Signature: _____ Print Name: _____
Relationship to patient:_____ Date:_____

Witness: _____ Print Name: _____