## Permission to Communicate with Family and Friends

So that we may serve you better you have the option of providing us a list of family and friends with whom we may discuss your health information.

By signing this form I give consent to Piedmont Family Dentistry to discuss health information with the people listed below who assist with my care**.**

**Do not discuss information about _____**

| **Name** | **Phone Number** | **Relationship** |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

_____

Signature of patient or legal guardian Date Print Patient Name

_____

Witness Date

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