I _____ give permission for
Print name

_____
Print name of authorized person/persons **relationship**

to access my dental information regarding my dental treatment and the costs associated with care through Cambridge Family Dental. Only the person/persons listed above may be given specific information. I have the right to sign a notice of revocation at any time to withdraw this approval.

_____
Signature of authorizing patient Date

Sign below only if revoking consent:

Revocation of Consent: I revoke my consent for sharing my dental information with _____.
print name of person/persons previously authorized

_____
Signature of patient revoking consent Date