



Ashly Bailey DDS
Logan Schuiteman DMD
Cosmetic + Family Dentistry

Confidentiality Authorization

Please sign one of the two options

I, _____, hereby authorize verbal and written release of information regarding my dental treatment, billing, and scheduling to the following:

Spouse: _____

Additional Family Members: _____

Other: _____

Signature: _____ Date: _____

Employee Witness: _____

OR

I, _____, do not wish to have any verbal or written information regarding my dental treatment, billing, and scheduling released to anyone.

Signature: _____ Date: _____

Employee Witness: _____