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Consent for Disclosure of Personal Information

info@westcalgarydentalgroup.com

I, _____, consent to the release of
(Name)

_____

(Identify nature of personal information)

to _____
(Identify individual/organization to whom information is released)

from _____
(Indicate where information is transferring from)

_____

I acknowledge that I have been made aware of the reasons for the disclosure of the above information, and the risks and benefits associated with consenting or not consenting to its release.

I understand that I make revoke my consent at any time, by providing a signed, written statement to my West Calgary Dental Group.

E-mail: _____ Telephone Number: _____

Signature: _____ Print Name: _____

Date: _____