Taylor B. Pope, DMD
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I understand there are very strict guidelines for confidentiality. My desire for release of my dental information is as follows:

☐ Release NO information without my written permission to any person or entity other than specified for insurance purposes.

☐ My dental condition may be discussed with the individuals listed below:

Spouse/significant other: _____

Others:_____
Name Relationship

_____
Name Relationship

_____
Name Relationship

I agree to the release of any information Dr. Taylor Pope feels is necessary for my care to other health care professionals involved in my care.

I realize it is my responsibility to make changes in my desire for release of dental information.

_____ _____
Patient/Legal guardian Witness

_____
Date