CONSENT

Deer Creek Dental Clinic, Ltd
820 North Superior Ave
Tomah, WI 54660
(608) 372-5000

I, _____hereby request and authorize Deer Creek Dental Clinic, Ltd. to disclose and provide any and all clinical treatment record and personal account information concerning my care to the below named individual. These records include: confidential health information, insurance explanation of benefits, prior authorizations and billing statements, which is in the possession of this person or entity. I also give permission for the named individual to schedule any necessary appointments.

_____(_____)
Name Relationship

_____
Address

_____
City State Zip

I expressly release from liability the above named persons or entity from any and all liability arising from compliance with the request and disclosure of the requested information. I understand that I may revoke this request at any time; however, it must be done in written form.

Signed: _____ Date: _____

_____ Declined