Community Health Center of Franklin County
Desmond Callan Community Health Center
413-772-3748   978-544-1576

PERMISSION TO RELEASE PATIENT DENTAL INFORMATION

If you have a spouse, friend or relative that may call on your behalf to obtain appointment dates and times, x-rays, etc., we **will not** give that information out unless his/her/their name(s) is written below and signed by you.

Patient Name: ______________________________ Date of birth: __________________

1. I hereby give permission to the Community Health Center of Franklin County to allow receipt of the following to those listed below:

☐ Written prescriptions
☐ Dental x-rays
☐ Referrals to Specialists

______________________________ Relationship: __________
______________________________ Relationship: __________
______________________________ Relationship: __________

should he/she/they call or come in to inquire.

~OR~

2. I do not allow any information about me released to anyone: ☐

PLEASE SIGN BELOW

Patient signature: ______________________________ Date: __________________

PLEASE NOTE:

This release of information does not include record requests to/from other doctor's offices, requests by insurance companies or other outside agencies. Specific releases will need to be obtained by the patient for these purposes.