ARCHER
DENTAL
Advancing dental care in our changing world

Consent Form

I ______________________________ hereby authorize _______________________________
(Print Name) (Print Name of Care Facility)
to disclose its patient medical records, including medical, dental and pharmaceutical health information, to Dr. Natalie Archer or any of her agents, in respect of the following patient.

Please provide any Pertinent Information/dental requests that you many have:

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I direct that this personal health information is to be used only the recipient or the purposes of a dental assessment and/or treatment. I hereby waive any and all claims against ____________________________ in connection with this disclosure of this personal information. I also authorize a complimentary dental screening to be completed by Dr. Natalie Archer and any of her agents.

Emergency contact: Phone Number

_________________________________ _________________________________

Contact numbers for future correspondence regarding dental treatment.

Email: Home Number:

______________________________________ ____________________________________

Work Number: Cell Number:

______________________________________ _____________________________________

______________________________________ ____________________________________
Signature Date