Michael R. Errico, DDS, FICOI, FAGD, PC & Associates

Disclosure of Dental Information

Name: _____ Date of Birth: _____

Patient confidentiality is of utmost importance to us and we prefer to give test results or other information directly to the patient. However, occasionally we are asked to release information to another individual.

Please choose from the following options:

O I want my test results/healthcare information reported ONLY directly to me.

O Dr. Michael Errico's staff has my permission to speak to myself or one of the following individuals listed below:

	Name	Phone #	Relationship
1.			
2.			
3.			

~ May we leave personal healthcare information on your answering machine? ___Yes ___No

~ May we contact you at work? ___Yes ___ No

If Yes, please provide your direct work number: _____
(Please print clearly)

Signature: _____ Date: _____