Marshall Dental, PLC
159 Lichfield Boulevard
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Fredericksburg VA 22406-

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(540)373-2273

marshalldentalva@gmail.com

Patient Name:* [Last] * [First] [MI] [Preferred Name]

Consent For Dental Information Release:

Purpose of Consent:

By signing this Consent form, you consent to disclosure of your protected health information in order to continue treatment by means of discussing dental options and/or financial arrangements.

Right to Revoke:

You have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to Marshall Dental. Please understand that revocation of this Consent will not affect any action in reliance on this Consent before we receive you revocation.

* ☐ I have received a copy of Marshall Dental's Notice of Privacy Practices.

List dependants (Under the age 18) you are including in this signature:

First/Last name & Date of Birth:

First/Last name & Date of Birth:

Please document below who we may Speak to concerning your personal dental, medical, and or financial information:

Name/ Relationship & Phone Number:

Name/ Relationship & Phone Number:

By signing, I acknowldge that I have read this statement and agree to the contents.

Signature: ______________________

Date:

Response Date: