Cleveland Family
DENTISTRY
Vic Uhrenholdt DDS, FAGD
Chris Aguirre DDS

CONSENT TO GIVE INFORMATION

I, _____give permission to Dr. Uhrenholdt and his employee/associates to give information to the people/persons listed below regarding financial information and treatment needed. I am aware of my rights to privacy, HIPPA notice of privacy practices act of 1996, and release Dr. Uhrenholdt and his employees/associates from any liability concerning the release of this information.

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Name:_____ Relationship:_____

Name:_____ Relationship:_____

Signature:_____ Date:_____

Witness:_____ Date:_____

205 E. Houston Cleveland, Texas 77327 • (O) 281-592-1234 • (F) 281-592-1245 • info@clevelandfamilydentistry.com