Drew Family Dental
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www.alexanderdrewdmd.com

MEDICAL/DENTAL RELEASE FORM

Patient Name_____

Date of Birth_____

- I authorize Alexander S. Drew, DMD, MS to freely contact me by mail, e-mail, or text for the purpose of annual/semi-annual recall appointments, appointment reminders, billing and any and all other correspondence.
- I authorize Alexander S. Drew, DMD, MS to freely contact me by phone, text and e-mail for the purpose of scheduling and/or appropriate reminders.
- I authorize Alexander S. Drew, DMD, MS to freely contact me by fax, phone, text, mail, e-mail for the purpose of delivering information that I have requested.
- I authorize Alexander S. Drew, DMD, MS to freely discuss all information pertaining to the treatment and account of the above referenced person to medical/dental professionals.
- I authorize Alexander S. Drew, DMD, MS to communicate with medical/dental professionals, insurance companies and third parties (trustees, guardians) via phone, fax, mail and e-mail. These transmissions may contain: medical, dental, accounts, insurance information as well as sensitive personal protected health care information.
- ***I realize there will be a fee for cancellations of appointments with less than 24 hour notice.***

Signed_____ Date_____

_____patient _____parent * _____guardian*

*of the above named patient

ADDITIONAL PERSON(S) ADD TO MY HIPAA _____

_____ Relationship to patient

_____

_____ Relationship to patient