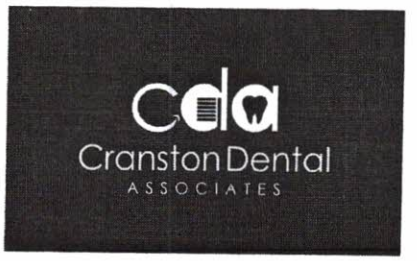

2000 Chapel View Blvd. Suite #370

Cranston, RI 02920

401-943-1412

Consent for Disclosure of Healthcare Information

Patient _____

I give (name of office) and staff permission to speak with the person(s) listed below regarding my dental health care, diagnosis, treatment and payments for services rendered.

Name _____ Phone # _____

Name _____ Phone # _____

Signature _____ Date _____

This consent is valid until I provide a written revocation of it