PAMELA J. ASSEFF, DDS, P.S.C

CONSENT FORM

Patient Name:
_____
(Please Print Full Name)

In case that I need Pamela J. Asseff, DDS, P.S.C to speak to someone other than myself regarding my dental care or my account information, I authorize the following person(s) to do so:

_____
_____
(Name) (Relation to patient)

_____
_____
(Name) (Relation to patient)

_____
_____
(Name) (Relation to patient)

I understand that in the case that I do **not** want any such person listed above to have the authorization to talk to Pamela J. Asseff, DDS, P.S.C regarding my dental care or account information; it is my sole responsibility to inform Pamela J. Asseff, DDS, P.S.C in writing of this immediately. We will use reasonable efforts to identify the person(s) designated providing that we bear no responsibility for disclosures for individuals who misrepresent themselves .

_____
_____
(Signature) (Date)

PAMELA J. ASSEFF, DDS
3046 BRECKENRIDGE LANE
SUITE #101
LOUISVILLE, KY 40220

(502)493-4154