

## Confidential Information Agreement

Please list the family members or other persons, if any, with whom we may discuss your dental treatment and/or your diagnosis:

Name \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_

Please list the family members or other persons, if any, with whom we may discuss your dental treatment **ONLY IN AN EMERGENCY**.

\_\_\_\_\_ Same as above

\_\_\_\_\_ No one

Name \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_

Please print the telephone number, if any, where you want to receive calls about appointments, billing and insurance inquiries, or dental healthcare questions.

Telephone Number \_\_\_\_\_

May confidential messages be left on the answering machine or voicemail number given above? Yes \_\_\_\_\_ No \_\_\_\_\_

If you do not have an answering machine or voicemail, may a confidential message be left with a secretary or personal assistant? Yes \_\_\_\_\_ No \_\_\_\_\_

**I understand that this agreement remains in effect until revoked by me in writing. If I revoke my consent, such revocation will not affect any actions that Dr. Vicki Borowski took before receiving my revocation.**

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date