THIS FORM IS ONLY FOR ANYONE 18yrs AND OLDER WHERE YOUR PARENTS ARE FINANCIALLY RESPONSIBLE FOR YOU BUT YOU ARE NOT COVERED UNDER THEIR INSURANCE

YOUR SYRACUSE

FAMILY DENTIST

VINCENT D. DIMENTO DMD

Date: ______________________

I ____________________________ authorize Dr Vincent D DiMento DMD
(Full Name)

to discuss any/all dental and/or medical pertaining to me with ____________________
(Name of person(s) you wish to share information with)

His/Her phone # Home/Cell ________________________

I **do/do not** wish Dr DiMento to contact this above named person directly with dental or medical information, prior to contacting me:

This authorization is valid from date above until further written notice is given or until

(Future date)

Signature:

Printed Name: