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PERMISSION TO SHARE INFORMATION

I _____, **GIVE PERMISSION TO SHARE ANY INFORMATION IN DR. GODSEY OR DR. GANDINI'S POSSESSION CONCERNING ME INCLUDING DENTAL AND FINANCIAL INFORMATION WITH THE FOLLOWING PERSON/PERSONS:**

1. **NAME** _____
RELATIONSHIP TO PATIENT _____
CONTACT NUMBER _____

2. **NAME** _____
RELATIONSHIP TO PATIENT _____
CONTACT NUMBER _____

3. **YOU MAY LEAVE MESSAGES FOR ME AT THE FOLLOWING NUMBERS:**

HOME: _____

OFFICE: _____

CELL: _____

PATIENT'S SIGNATURE

DATE