CONSENT FOR THE RELEASE OF HEALTH AND BILLING INFORMATION

I give my permission for the following persons to speak with Tracy L. Wolff DDS PC regarding my information (circle Health, Billing or Both)

HEALTH, BILLING, or BOTH. (PLEASE CIRCLE)

1.______________________________Relationship_____________HEALTH BILLING BOTH

Phone #________________________

2.______________________________Relationship_____________HEALTH BILLING BOTH

Phone #________________________

3.______________________________Relationship_____________HEALTH BILLING BOTH

Phone #________________________

Where is it okay to leave a message regarding health and/or billing information?

Phone #________________________

____DATE__________________________

Patient Signature