Authorization Form

Due to the new privacy acts, we must have your authorization to discuss anything regarding your dental appointments or dental health with anyone other than yourself. Please list below up to three people that you give authorization to do so.

I, _____, authorize any information regarding my dental records to be discussed with the below named individuals.

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Signature _____ Date _____

KENNETH E. SYKES, D.D.S.
1100 BRIDGEWOOD DRIVE SUITE 126 • FORT WORTH, TEXAS • 76112
PHONE: 817-451-4911 • FAX: 817-451-6443