WILLIAM A. DEIGHAN, D.M.D.
MARK E. GRUBB, D.D.S.

NORTHEAST ORAL & MAXILLOFACIAL SURGERY ASSOCIATES, P.A.

PERMISSION FOR OTHER THAN PARENT OF RECORD
TO RECEIVE A PATIENT'S TREATMENT, BILLING, AND APPOINTMENT INFORMATION

Name of the Patient: _____

I, (please print)_____ ***as (Parent / Guardian/ Patient of Age)*** am giving Northeast Oral & Maxillofacial Surgery Associates PA, permission to release treatment, billing, and appointment information about services provided for the above named patient to:

(Please Print)

Name:	Contact Info:
Name:	Contact Info:
Name:	Contact Info:

These individual(s) may bring this patient in for dental surgery. In addition, these individual(s) will be able to make future appointments for treatment if needed.

Signed:_____Relationship to Patient:_____

Date:_____

Please Complete Reverse Side