GRAND STRAND DENTISTRY

1867 B Hwy 544

Conway, SC 29526

I, _____, hereby authorize Grand Strand Dentistry to give the following people information concerning my health, treatment, billing and/or insurance information:

____ Spouse Name: _____

____ Significant Other Name: _____

____ Any Specified Person Name: _____

The following information may be given to the above individual (s) :

____ Appointment Time

____ Pre and Post Op Instructions

____ Any information regarding my dental treatment

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Messages may be left on my answering machine(s) regarding the above:

____ Yes _____ NO

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I understand I may terminate this consent anytime by giving written notice to Dr. Brian K. Armstrong. Any changes to this form will require a new consent form to be completed, signed, and dated.

Signed: _____ Date: _____

Witness: _____ Date: _____