DENNIS D. DEWEY, M.D.

PERMISSION TO SHARE HEALTH INFORMATION

I HAVE AUTHORIZED DR DEWEY'S OFFICE TO DISCLOSE MY HEALTH INFORMATION TO THE FOLLOWING LIST OF PERSONS WHO MAY CALL ON MY BEHALF:

NAME RELATIONSHIP

1. _____

2. _____

3. _____

4. _____

PATIENT SIGNATURE: _____

STAFF SIGNATURE: _____

DATE: _____