Weininger Dental, LLC
249 Fair Ave NW
New Philadelphia, OH, 44663

Date:_____

Print Name:_____Date of Birth:_____

I have received a copy of this office's Notice of Privacy Practices.

I understand that I may revoke this authorization at any time, and that my revocation is not effective unless it is in writing and received by the dental practice Weininger Dental at: 249 Fair Ave, NW, New Philadelphia, Ohio. If I revoke this authorization, my revocation will not affect any actions taken by the dental practice before receiving my written recovation.

I understand that I may refuse to sign this authorization, and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

I authorize the following person(s) to recieve my patient information regarding:
Appointments, Insurance, Payments, and Treatment

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

Signature:_____