

**Consent Form**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, give \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ permission

 (Name of Patient) (Name of Authorized Individual)

to discuss any appointments and/or treatment related to my care as well as pick up any documents/cases on behalf of me. This consent will be valid as of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ unless revoked in writing to Granite Family Dentistry. (Date)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature