

DELAINÉ ANTHONY, DMD, PC

---

**CONSENT FOR USE AND DISCLOSURE  
OF HEALTH INFORMATION**

---

I, \_\_\_\_\_, hereby grant permission to disclose necessary information relating to my treatment or my dependent(s) \_\_\_\_\_ to the parties listed below.

---

Relationship to patient or dependent

---

Relationship to patient or dependent

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_