Melanie Pugh, DMD, PA
Gentle Family & Cosmetic Dentistry

____ **I DO NOT** give the office of Dr. Melanie Pugh my permission to discuss my account, treatment or any other protected health information with anyone other than myself.

____ **I DO** give the office of Dr. Melanie Pugh my permission to discuss my account, treatment, or any other protected health information with the following:

_____
_____

NAME RELATIONSHIP

_____
_____

NAME RELATIONSHIP

May we leave a message at home confirming or cancelling an appointment?

YES NO

May we leave a message at your place of employment to have you return our call?

YES NO

_____
_____

Signature **Date**