CONSENT FOR DISCLOSURE OF HEALTH and PERSONAL INFORMATION

I, _____, hereby give the office of Joseph S. Gay, D.D.S. consent to release my health and personal information to my insurance company.

I authorize payment to be made directly to Joseph S. Gay, D.D.S. I am aware that I am financially responsible for any fees not paid by my insurance carrier.

Please print your name _____

Signature _____ Date_____