CENTRAL COAST Smiles

Guy Alexander Jones, DDS

I _____, give my permission to Guy A. Jones, DDS and his staff at Central Coast Smiles; to speak with _____, my _____, regarding my treatment plan or financial arrangement without my presence. I waive my HIPAA, rights.

_____ _____

Name Date

Please contact me with any questions and or concerns at this address or phone below:

_____

_____

_____

_____

(This release will remain in effect until a written release is given to the practice by you to void this release.)

931 Oak Park Blvd. Suite 202
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(805) 489-7645