Dr. Lisa A. Goff, D.M.D.
2717 N. Wickham Rd. #2
Melbourne, Florida 32935
321-242-2766

INFORMATION RELEASE FORM

In order to assist you in receiving your information from Dr. Goff's office, please complete this form.

I authorize the persons listed below to have access to any and all of my dental information. Dr. Goff's office is permitted to share any information with them, including any information disclosed during any office visit.

NAME	RELATIONSHIP	PHONE NUMBER

You may notify me or the parties listed above with appointment reminders, account information, and any other information regarding my dental information as follows:

_____ Message on answering machine (Phone Number) _____

_____ Message on work voicemail (Phone Number) _____

_____ Message on pager (Phone Number) _____

_____ Message on cell phone (Phone Number) _____

_____ Other _____

I understand and direct that this authorization will remain in effect until it is revoked by me in writing.

_____	_____
Patient - Print Name	Witness - Print Name
_____	_____
Patient - Signature	Witness - Signature
_____	_____
Patient - Date	Witness - Date