

**Alan G. Siegel, D.D.S., P.C.**  
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I authorize Dr. Siegel and his staff to release all information necessary for other healthcare providers to proceed with treatment.

I authorize Dr. Siegel and his staff to release all information necessary to secure payment of benefits from my insurance companies.

I consent to the use of all information I have provided to help determine appropriate and healthful dental treatment by Dr. Siegel and his staff.

I consent to the use of all information I have provided to help determine follow up care.

I consent to the leaving of messages on my phone, the phone at my workplace or with my answering service at home or at my workplace in reference to my, my family's, and/or my associate's appointments.

I consent to Dr. Siegel and his staff using e-mail to contact me if I have that capability if and when the office uses that form of communication.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date