



Hamilton Mill
Oral And Facial Surgery

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*Diplomate of the American Board of Oral and Maxillofacial Surgery
Diplomate of the National Dental Board of Anesthesiology*

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AUTHORIZATION TO DISCUSS MEDICAL CARE / PATIENT ACCOUNT

I hereby authorize Hamilton Mill Oral and Facial Surgery, LLC to discuss any of my medical care needs (including appointment, results, continuing care and treatments) with the following people:

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

I hereby authorize Hamilton Mill Oral and Facial Surgery, LLC to discuss any of my Patient Account information with the following people:

Same as above

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

Patient/Personal Representative Name (print): _____

Patient/Personal Representative's Signature: _____

NOTE: If you wish to not list anyone, please print “DECLINE” and sign on the signature line.