RELEASE OF CONSENT FOR TREATMENT

Patient's name: ________________________________ DOB:_____________________

1) People who may bring my child to dental appointments are:

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(This includes operative appointments and allows this person to sign for treatment to be done at the operative visit, sign for any changes that may occur with treatment at the visit, and receive post operative instructions for care of my child after the visit)

2) People who may sign or consent to a proposed treatment plan are:

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3) People who may receive a copy of my child's records including radiographs:

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* Please provide contact information for these people: (please provide name, phone, and address)

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I understand that Pediatric Dentistry of Haslet will be unable to release ANY information to anyone other than the person/persons listed above. I understand my child MAY NOT BE SEEN FOR TREATMENT if the person bringing my child is not listed above.

My consent is freely given. I understand that I may revoke this consent at any time if that revocation is in writing, but any disclosures given to the persons listed above prior to revocation of consent will be permissible.

Parent/Guardian Printed Name: ____

Parent/Guardian Signature: ____________________________________Date:_______________