



**Authorization for the release of dental information**

To:

\_\_\_\_\_  
Health care provider

\_\_\_\_\_  
Street address

\_\_\_\_\_  
City State Zip code

( ) \_\_\_\_\_

Telephone No.

You are hereby authorized to release to \_\_\_\_\_ and its representatives, any and all information you may have concerning my child's dental condition, including x-rays, which you have obtained as a result of history, examinations, testing, diagnosis, treatment and prognosis.

This authorization shall remain valid for one year from today's date. A signed copy of this authorization is as valid as the original.

I realize that I am entitled to have a copy of this signed authorization and DO / DO NOT (circle one) request a copy, and if requested, do acknowledge a receipt thereof.

I have read this authorization before signing it.

\_\_\_\_\_  
Signature of Parent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print or type name of patient(s)

If not signed by the patient, please indicate relationship.

- ( ) parent or guardian of minor patient
- ( ) guardian or conservator of incompetent patient
- ( ) beneficiary or personal representative of deceased patient

