Additional Caregiver Consent

I _____ give Pediatric and Adolescent Dentistry permission to speak with the following people regarding my child(s) health status, including diagnosis, treatment options/plans as well as payment for health service received.

Child(s) Names:

_____ _____ _____

The office may speak with:

Name: _____

Phone: _____

Relationship to Child(s) _____

Information to be released:

Treatment __ Diagnosis __ Schedule __ Payment __ Other __

Name: _____

Phone: _____

Relationship to Child(s) _____

Information to be released:

Treatment __ Diagnosis __ Schedule __ Payment __ Other __

This consent is valid until such time as I provide a written revocation of it.

Signature _____

Relation to child(s) _____

Date_____