LOCKPORT DENTAL GROUP

RELEASE OF DENTAL INFORMATION for a MINOR

Patient Name: _____ Date of Birth: ____/____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records, examination, pre-op and post op instructions rendered to my child(ren), and claims information. This information may be released to:

[ ] Spouse (Parent) _____

[ ] Other (Grandparent – other Guardian, etc.) _____

I do not authorize any release of information to the following people:

[ ] Spouse (Parent) _____

[ ] Other (Grandparent – other Guardian, etc. _____

This **Release of Information** will remain in effect until terminated by the guardian in writing.

Messages

The best time to reach me personally is (day) _____ between (time) _____

Please call

[ ] my home phone [ ] my work number [ ] my cell number

_____ _____ _____

If unable to reach me:

[ ] you may leave a detailed message [ ] please leave me a message asking for a return call

Print name: _____

Relationship to patient: _____

Signature: _____ Date: ____/____/_____