Just Kids DENTAL
General and Specialty Dentistry for Kids

AUTHORIZATION FOR TREATMENT AND RELEASE OF INFORMATION

I ______________________________ the parent of ______________________________ with Date of Birth ________________ authorize the following persons below to bring my child to his/her dental appointments, and **Just Kids Dental** to provide them with any information necessary in keeping with the patient's home care instructions. **I authorize these persons to make treatment decisions and provide consent on my behalf; I recognize that there will be times when my presence and a signature will be required for certain procedures. I understand if my child is present with someone not listed below, my child will not be seen.**

PLEASE NOTE HOW WE MAY CONTACT YOU

☐ All numbers available /including voice mail

☐ Home/including voicemail ☐ Home/No voicemail

☐ Work/including voicemail ☐ Work/No voicemail

☐ Mobile/including voicemail ☐ Mobile/No voicemail

AUTHORIZED PERSONS TO RECEIVE INFORMATION Check each person that you approve to receive information.	DESCRIPTION OF INFORMATION TO BE RELEASED Check each that can be given to person on the left in the same section.
☐ Other Parent (provide name) ____________________	☐ Appointment information ☐ Family Billing information ☐ Co-pays due at appointment ☐ Treatment information
☐ Other (provide name) ____________________ Relationship to patient ____________________ Phone number: ____________________	☐ Appointment information ☐ Family Billing information ☐ Co-pays due at appointment ☐ Treatment information
☐ Other (provide name) ____________________ Relationship to patient ____________________ Phone number: ____________________	☐ Appointment information ☐ Family Billing information ☐ Co-pays due at appointment ☐ Treatment information
☐ Other (provide name) ____________________ Relationship to patient ____________________ Phone number: ____________________	☐ Appointment information ☐ Family Billing information ☐ Co-pays due at appointment ☐ Treatment information
☐ Other (provide name) ____________________ Relationship to patient ____________________ Phone number: ____________________	☐ Appointment information ☐ Family Billing information ☐ Co-pays due at appointment ☐ Treatment information

Rights of the Patient

In Accordance with HIPPA regulations, I understand I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to Just Kids Dental. I understand any changes in this form are not effective in cases where the information has already been disclosed, but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

______________________________ ______________________________

SIGNATURE OF PARENT OR GUARDIAN DATE