Pediatric Dentistry

AUTHORIZATION

Patient Name:______________________ Date of Birth:___________

Patient to complete the following:

I authorize ____to use and/or help determine treatment for the following people:

____

____

This authorization is valid from________________ and expires on______________

I understand that I may refuse to sign this authorization.

I understand that you cannot condition provision of services or treatment based on whether or not I sign this authorization.

I understand that I have the right to revoke this authorization at any time by providing written notice to the organization. I also understand that the revocation is not applicable to information already disclosed while the authorization was in effect.

Signed:_______________________________ Date:___________________

Please file in patient chart and provide copy to patient at time of signature.

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