

RIDGE DENTAL GROUP, LTD

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 OR

[] you may e-mail me at _____ OR Text Me at: _____

Guardian: _____ Date: ____/____/_____

Witness: _____ Date: ____/____/_____