Bebar Family Dental/ Dr. Bebar

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:

[ ] Parent (Mother/Father) _____

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

_____

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

[ ] Parent (Mother/Father) _____

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

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

Messages

Please call

[ ] my home phone [ ] my work number [ ] may text 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 _____

Guardian: _____ Date: ____/____/_____

Witness: _____ Date: ____/____/_____