Release of Information Authorization

I authorize Fox Kids Dentistry & Orthodontics to release the designated protected health and/or account information to the individuals listed below (other parents, grandparents, pediatricians, etc.):

_____ _____

Name of person to receive information Relationship to patient

Is authorized to receive (check all that apply):

- □ Health history
- □ Account information
- □ Appointment dates & times
- □ Dental history
- □ Insurance information
- □ Treatment plans

_____ _____

Name of person to receive information Relationship to patient

Is authorized to receive (check all that apply):

- □ Health history
- □ Account information
- □ Appointment dates & times
- □ Dental history
- □ Insurance information
- □ Treatment plans

I make this authorization freely and of my own volition. I agree to hold Fox Kids Dentistry & Orthodontics harmless from any and all outcomes resulting from the release of designated information. I understand I may revoke this authorization in writing at any time.

Signature of parent/guardian: _____

Print name: _____

Child's name: _____ Date: _____