



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):

- | | |
|--|--|
| <input type="checkbox"/> Health history | <input type="checkbox"/> Dental history |
| <input type="checkbox"/> Account information | <input type="checkbox"/> Insurance information |
| <input type="checkbox"/> Appointment dates & times | <input type="checkbox"/> Treatment plans |

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|--|--|
| <input type="checkbox"/> Health history | <input type="checkbox"/> Dental history |
| <input type="checkbox"/> Account information | <input type="checkbox"/> Insurance information |
| <input type="checkbox"/> Appointment dates & times | <input type="checkbox"/> 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: _____