clark
PEDIATRIC DENTISTRY

Authorization for Treatment and Release of Information to Family and/or Friends

Name of Patient:_____ **Date of Birth**: _____

I hereby authorize _____ to attend dental appointments with the above child. By authorizing the above person to attend dental appointments, with the named child, I understand that the following information can and may be released:

1. Dental treatment, including any changes in dental treatment.
2. Financial.
3. Diagnostic tests (ie. X-rays).
4. Medical History.
5. Any information necessary for dental treatment.

Authorization dates:
If you would like this authorization to end, please enter a date. If no end date, write "continuous." _____

Rights of the patient:

1. I have the right to revoke this authorization at any time, and I have the right to inspect or copy the protected health information to be disclosed as described in the document by sending a written notification to: Clark Pediatric Dentistry
2. A revocation is not effective in cases where the information has already been disclosed, but will be effective going forward.
3. Information used or disclosed, as a result of this authorization, may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
4. I have the right to refuse to sign this authorization and that my treatment in my presence will not be conditioned on signing this authorization.
5. This authorization shall be in force and effective until revoked by the patient or the representative signing the authorization.

Responsibilities of the Patient and Legal Guardian:

All financial policies remain in effect. Any financial arrangements must be taken care of prior to the appointment. Payment, for services rendered, is due at the time of treatment. If payment arrangements are not made prior to the appointment, the authorized person (whoever accompanies the child) will be financially responsible.

I understand that it is my responsibility to inform Clark Pediatric Dentistry of any changes in my child's medical history prior to the dental appointment.

Signature of Legal Guardian: _____ **Date:** _____

Relationship to Patient: _____

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