Midlands Pediatric Dentistry

Authorization for Treatment and Release of Information

By signing this authorization, I understand I am giving authorization to the person(s) listed in the box below to bring my child to his/her dental appointments and give permission to Midlands Pediatric Dentistry to provide them with the information regarding my child's dental appointments, evaluations, treatments and billing. Midlands Pediatric Dentistry may also discuss medical history with the person(s) listed below. I authorize the person(s) to make treatment decisions on my behalf. I recognize there will be times when my presence and/or my signature will be required for certain procedures. I understand if my child is present with someone not listed below he/she will not be seen. I understand I must request in writing for a person to be removed from this list.

Name	Contact Phone Number	Relationship to Child

Child(ren) and Date of Birth

_____
Signature

_____
Print Name

_____
Relationship to Child

_____
Date

_____

_____

_____

_____