

AUTHORIZATION FOR RELEASE OF INFORMATION

Print Patient Name: _____ Date of Birth: _____

Print Parent / Guardian Name: _____

Parent / Guardian email: _____

Relationship to patient: Mother Father Step-Parent

***Do you want to give authorization for someone other than yourself to have access to the patient's information?**

- NO, I do not want to give access to anyone.
- YES, I give permission to release the following information:
 - Test or x-ray results
 - Appointment information
 - Billing information
 - Insurance information
 - Treatment / medical information

YES, I do want to give access to the following individuals:

	NAME	RELATIONSHIP TO PATIENT	PHONE
1.	_____		
2.	_____		
3.	_____		
4.	_____		

Parent / Guardian Signature: _____