Chastain
DENTAL STUDIO

Medical Release Form for Minors

I, _____,(Parent/Legal Guardian) authorize the following person/persons to authorize dental treatment for my child/children by this facility. I also authorize this office to release and/or disclose my child(ren)'s private health information, defined here as the patient's complete dental record, including treatment, prognosis, financial, billing, and insurance information to representatives below.

I understand that I am responsible for services rendered for treatment and payments authorized by my representatives.

The purpose of this request to release and/or disclose the PHI described above is for personal reasons. I understand that I have the right to revoke this authorization, in writing, at any time by notifying the office above. Such revocation will not affect actions taken by the requesting person prior to the date he or she received the written revocation. I also understand information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and will no longer be protected by this rule.

I understand that my health care provider cannot condition treatment on whether I sign this

Authorization. This Authorization will expire at such time that:

___ I decide to revoke this Authorization in writing; OR

___ The following date: _____ (within one year of current date).

REPRESENTATIVE NAME	RELATIONSHIP	DOB	PHONE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

NAME OF CHILDREN	AGE
_____	_____
_____	_____

Signed by: _____

Relationship to Child: _____ Date: _____