PERMISSION FORM

I, _____mother/father/legal guardian **GIVE / DO NOT GIVE** (circle one) my permission for Dentistry for Children and Adolescents, Ltd. to communicate and share information regarding appointments, treatment planning, and financial arrangements with the following individual(s) when parent or guardian is not present.

NAME	RELATIONSHIP TO PATIENT
NAME	RELATIONSHIP TO PATIENT
NAME	RELATIONSHIP TO PATIENT

Regarding the following patient (s):

_____

PATIENT'S NAME

_____

PATIENT'S NAME

_____

PATIENT'S NAME

I have read and understand the conditions of the form. The permission is valid unless revoked by legal guardian or Dentistry for Children and Adolescents, Ltd.

Signature of parent/legal guardian: _____

Date: _____