The following people are allowed to act on my behalf in concern to my child(ren):

_________________________________________  ________________________
Individual’s Name (Print)                  Relationship to patient(s)

_________________________________________  ________________________
Individual’s Name (Print)                  Relationship to patient(s)

_________________________________________  ________________________
Individual’s Name (Print)                  Relationship to patient(s)

I authorize the above listed individuals to do or receive the following:

INITIAL next to the what you authorize

___ Bring my child(ren) to appointments
___ Authorize treatment/services for my child(ren)
___ Obtain any dental or medical information about my child(ren)
___ Give medical information about my child(ren)
___ Receive information about appointments for my child(ren)
___ Make appointments for my child(ren)
___ Give insurance and/or demographic updates about my child(ren)

I, ____________________________, hereby authorize the use and disclosure of the patient information as described in the Notice of Privacy Practices, for the items initialed above, for the following patient(s).

Patient Name(s) __________________________________________________________________________

I understand that I may revoke this authorization at any time, and that my revocation is not effective unless it is in writing and received by the dental practice’s Privacy Official at:
3401 El Salido Parkway, Cedar Park, Texas 78613 OR front@secure.texastoothfairies.com.

If I revoke this authorization, my revocation will not affect any actions taken by the dental practice before receiving my written revocation.

Furthermore, I understand, according to Texas Tooth Fairies Pediatric Dentistry’s Financial Policy, payment is due from whoever is accompanying the patient to their appointments at the time of service. If I do not intend on the above individuals to make payment on my behalf I will secure or make payment to the office before my child(ren)’s appointment.

SIGNATURE OF PARENT, GUARDIAN OR RESPONSIBLE PARTY  RELATIONSHIP TO PATIENT(S)  DATE