TEXAS TOOTH FAIRIES PEDIATRIC DENTISTRY
PAMELA R. SINGLETARY, DDS & JEFFREY B. GREGERSON, DMD

AUTHORIZATION FOR USE AND DISCLOSURE TO INDIVIDUAL(S) OTHER THAN PARENT OR GUARDIAN

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)

initial____ Bring my child(ren) to appointments

initial____ Authorize treatment/services for my child(ren)

initial____ Obtain any dental or medical information about my child(ren)

initial____ Give medical information about my child(ren)

initial____ Receive information about appointments for my child(ren)

initial____ Make appointments for my child(ren)

initial____ Give insurance and/or demographic updates about my child(ren)

I, ____________________________ (Print Name), 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**