TEXAS TOOTH FAIRIES PEDIATRIC DENTISTRY
Pamela R. Singletary, DDS Jeffrey B. Gregerson, DMD
Michelle J. Kim, DDS Sheetal R. Asher, DMD (Board Eligible)
Diplomats of the American Board of Pediatric Dentistry

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:

- 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, _____ (Parent Name-PRINT), hereby authorize the use and disclosure of the patient information as described in the Notice of Privacy Practices, for the items stated 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**