Release of Information Authorization

I authorize Sprout Pediatric Dentistry & Orthodontics to release the designated protected health and/or account information to the individuals listed below (other parents, grandparents, pediatricians, etc.):

______________________________________ ______________________________
Name of person to receive information | Relationship to patient

Is authorized to receive (check all that apply):

- ☐ Health history
- ☐ Account information
- ☐ Appointment dates & times
- ☐ Dental history
- ☐ Insurance information
- ☐ Treatment plans

______________________________________ ______________________________
Name of person to receive information | Relationship to patient

Is authorized to receive (check all that apply):

- ☐ Health history
- ☐ Account information
- ☐ Appointment dates & times
- ☐ Dental history
- ☐ Insurance information
- ☐ Treatment plans

I make this authorization freely and of my own volition. I agree to hold Sprout Pediatric Dentistry & Orthodontics harmless from any and all outcomes resulting from the release of designated information. I understand I may revoke this authorization in writing at any time.

Signature of parent/guardian: ____

Print name: ____

Child's name: _____________________________________ Date: __________________________