SHORELINE
PEDIATRIC DENTISTRY

PAUL FIELD, DDS
•2435 Ridge Rd • Suite #117 • Rockwall, TX 75087 •
• 972-21-SHORE (972-217-4673) • www.shorelinekidsteeth.com •

Authorization For Treatment And Release Of Information To Family And/Or Friends

Child(ren)'s Full Name(s): _____

DOB(s): _____ , _____ , _____ , _____ , _____

I hereby authorize the following individual(s) to attend dental appointments with the above child(ren) to the office of Shoreline Pediatric Dentistry:

Authorized Person's Full Name And Relationship To Patient(s): _____

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By authorizing the above person(s) to attend dental appointments, with the named child(ren), I understand that the following information can and may be released:

- Dental treatment (including any changes in dental treatment)
- Financial
- Diagnostic tests (e.g. X-rays)
- Medical history
- Any information necessary for dental treatment

Authorization Dates:
If you would like this authorization to end, please enter a date. If no end date, please write "continuous."
Date (MM/DD/YYYY): _____

Parent / Legal Guardian Rights:

- I have the right to revoke this authorization at any time, and I have the right to obtain the protected health information to be disclosed as described in this document by sending a written notification to Shoreline Pediatric Dentistry.
- A revocation is not effective in cases where the information has already been disclosed, but will be effective going forward.
- Information used or disclosed, as a result of this authorization, may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- This authorization shall be enforced and effective until revoked by myself, the parent/guardian, signing the authorization.

Parent / Legal Guardian Responsibilities:
All financial policies remain in effect. Any financial arrangements must be taken care of prior to the appointment. Payment for services rendered is due at the time of treatment. If payment arrangements are not made prior to the appointment, the authorized person, whoever accompanies the child(ren), will be financially responsible at the time of the appointment. I understand that it is my responsibility to inform Shoreline Pediatric Dentistry of any changes in my child's medical history prior to any dental appointment.

Print Parent Or Legal Guardian's Name: _____

Relationship to Patient(s): _____

Parent / Legal Guardian Signature: _____ Date: _____