Speedway PEDIATRIC DENTISTRY

Dillon T. Wiley, DDS, MSD

# Authorization for Consent or Release of Patient Information

In accordance with HIPAA guidelines, our office works very hard to protect your privacy and the privacy of your child while in our care. We understand that you may need us to provide information to a representative in your absence or forward records. Please fill out the authorization below if you would like us to share any information regarding your child and care received in our office or if you allow someone to consent to treatment in your absence.

Patient Name: _____ D.O.B.: _____

Patient Name: _____ D.O.B.: _____

Patient Name: _____ D.O.B.: _____

Authorization Valid from _____ to _____ ,unless written notification is received by the office.
Please indicate letter(s) (A,B,C) for authorization to allow Speedway Pediatric Dentistry and staff to:

A. ☐ Please allow, _____ , to provide consent for treatment for named patient(s). Please note that this authorization allows named representative to accompany child/children to appointments in parent's absence and to consent for any necessary treatment or treatment plan changes in office.

B. ☐ I, _____ , understand that I will be financially responsible for all treatment rendered when authorized by named individual from A. I will make timely payments of co-pays to keep account current and realize that payment will be due at time of treatment.

C. ☐ Please release all necessary dental records / Xrays or requested information to the following:
Office/Doctor's name: _____
Office address: _____
Office address 2: _____
Office phone/email: _____

Printed Name: _____ Relationship to Patient(s):_____

Signature: _____ Date: _____