SCHIMP
FAMILY DENTISTRY

AUTHORIZATION TO SHARE DENTAL INFORMATION

Ages 0-13

Patient Name: _____ Date of Birth: _____

I authorize the following individual(s) to accompany my child to dental appointments. These individuals may receive private dental information and discuss treatment recommendations.

Please check the box to the left if this individual(s) can make decisions regarding my child's dental care in my absence. This includes, but is not limited to, approving X-rays, fluoride treatments, and routine preventive or restorative care.

- ☐ Name: _____ Relationship: _____
- ☐ Name: _____ Relationship: _____
- ☐ Name: _____ Relationship: _____
- ☐ Name: _____ Relationship: _____
- ☐ Name: _____ Relationship: _____
- ☐ Name: _____ Relationship: _____

This authorization will remain in effect until revoked in writing by a parent or guardian, or the patient turns 18 years of age.

Parent / Guardian Name: _____

Parent / Guardian Signature: _____

Date: _____