



Patient Information Authorization

972.608.4746
972.608.4749 fax

This form is to be completed for any other person bringing the child/children in for their dental appointments other than the natural mother or father or legal guardian.

Patient Name Birthdate
Patient Name Birthdate
Patient Name Birthdate
Patient Name Birthdate
Patient Name Birthdate

I give Grin Central Station LLP permission to discuss the indicated aspects of my account with the following person(s).

(Please check all that apply)

- Can consent to (sign consent) and discuss recommended treatment
Can schedule appointments
Can discuss financial arrangements
Can discuss information related to insurance coverage and payments
Can discuss completed treatment

1. (Print name) (Relationship to patient)
2. (Print name) (Relationship to patient)
3. (Print name) (Relationship to patient)

Signature Date
(Natural mother or father or legal guardian)

This authorization will remain in effect until it is revoked in writing by the natural mother, father, or legal guardian listed above.