DENTAL ASSOCIATES OF WALPOLE

Family ◦ Specialty ◦ Care

FOR A MINOR CHILD

AUTHORIZATION TO RELEASE INFORMATION

DATE: _____

I, _____ , parent or guardian of

_____ date of birth:_____ give my permission to Dental Associates of Walpole to discuss treatment provided and treatment recommended with the persons listed below until such time as I notify Dental Associtates of Walpole in writing that I am rescinding this authorization:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signed (parent or legal guardian): _____

Print name (parent or legal guardian):_____