

This authorization is for _____ (if patient is a minor, parent or guardian must sign)

I give permission for the dentist and her staff to discuss the noted items below with the following family members:

___ Appointments

___ Billing/Fees

___ Treatment

Date _____ Signed _____

Date _____ Signed _____

Date _____ Signed _____

Date _____ Signed _____

Date _____ Signed _____

Date _____ Signed _____

Date _____ Signed _____

Date _____ Signed _____

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