



Consent to Treat & Release of Information

Patient's Name: _____

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

I consent to the dentist's use and disclosure of my records, or of my child's records, to carry out treatment, to obtain payment, and for those activities and health care operations that are related to the treatment or payment.

My consent for treatment and disclosure of records shall be effective until I revoke it in writing.

I understand and agree that I am responsible for payment of the bill.

Authorization:

Print Name & Relationship to Patient: _____

Signature: _____ Date: _____