Providence Specialty Pediatric Dental Clinic

Others Involved In Health Care

Patient Name: ______________________________________ **DOB:** ___________

This form is stating that you as a Parent/Legal Guardian of a Providence Specialty Dental Clinic patient would like to elect to have others involved in your health care. Without your prior approval, we cannot discuss any medical information or complete any treatment/procedures. Please list the names of those you would like listed as being involved in patients' health care. This information can be changed or revoked with your permission at any time. I give permission for information related to my child's current health status to be discussed with and/or consented for by:

Name ___________________________________ **Relation to patient**___________________

Phone Number: (H / W / C) ______________________________

Name ___________________________________ **Relation to patient**___________________

Phone Number: (H / W / C) ______________________________

I understand that this might include consenting to and/or discussing such information as: diagnosis, prognosis and treatment plans, extractions, stainless steel crowns, pulp treatments, fluoride, amalgam and/or composite restorations, medications, discharge and instruction plans, diagnostic test results, appointment reminders, medical billing, insurance, and any other medical information relevant to my child's care.

Parent/Legal Guardian's Signature: _________________________________ **Date:** __________

Parent/Legal Guardian's printed name: ______________________________

Relation to patient: ________________________________