AUTHORIZATION TO RELEASE INFORMATION

Date: _________________________

I, _____________________________________ give my permission to Natick Dental Partners and staff to discuss treatment provided and treatment recommended with the persons listed below until such time as I notify Natick Dental Partners and staff in writing that I am rescinding this authorization:

Name: __________________________ Relationship: _________________________

Name: ___________________________ Relationship: __________________________

Name: ___________________________ Relationship: __________________________

Name: ___________________________ Relationship: __________________________

Signed: __________________________________

DENTAL HEALTHCARE PROXY

Date__________________________

I_____________________________________, Parent or legal guardian, authorize

____to consent to treatment for all dental

Procedures for ____(name/ names of

children). This proxy shall remain in force until such time as I rescind it.

Signed:____

Legal relationship to patient___________________________

***Please email completed form to records@gotfloss.com**