Dentistry for Children & Adolescents, Ltd.

Dr. Kala Hinz
Dr. Vera Kenderian

PERMISSION FORM

I, _____, mother/father/legal guardian give my permission for the staff at Dentistry for Children and Adolescents, Ltd. to communicate and share information regarding appointments, treatment planning, and financial arrangements in writing and conversation with the following persons **(other than parents):**

_____	_____
Name	Relationship to Patient
_____	_____
Name	Relationship to Patient
_____	_____
Name	Relationship to Patient

Regarding the following patient(s):

_____
Patient's Name

_____
Patient's Name

_____
Patient's Name

I have read and understand the conditions of this form. This permission is valid unless revoked by a legal guardian or Dentistry for Children and Adolescents, Ltd.

Signature of parent/legal guardian: _____

Daytime phone numbers: _____ _____

Parent/Guardian Email Address: _____

Date: _____

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