

Pediatric Dentistry

1439 Stillwater Suite #7, Cheyenne WY 82009

RELEASE OF CONSENT FOR TREATMENT

I understand that by signing this form I consent to the following:

Allow the person(s) listed below to act in the place of a parent or guardian (*in loco parentis*) for the children listed below in respect of any circumstances, including any accident or illness, which may necessitate medical treatment, including dental treatment, and on my behalf to authorize any such treatment or surgery which they, in their sole discretion, (which discretion shall not be unreasonably exercised), may deem necessary. Medical treatment for the Child or children may also include dental surgery, x-rays, anesthetic and medication provided any such treatment is performed by a duly licensed practitioner or qualified staff members. I hereby accept full liability for all costs incurred through such dental/medical treatment for the children listed below. I also permit changes in my child's treatment and information to be left with these individual(s).

Child or Children's Name(s): _____

Child or Children's Date of Birth: _____

Name _____

Address _____

City _____ State _____ Zip _____

Phone number _____

Name _____

Address _____

City _____ State _____ Zip _____

Phone number _____

I understand that besides parents or legal guardians we will be unable to release ANY information to anyone other than the person/persons listed above.

My consent is freely given. I understand that I may revoke this consent at anytime if that revocation is in writing, but any disclosures given in reliance on this prior consent will be permissible.

Parent/Guardian Signature _____

Today's date _____

If more room is needed, please use bottom of this form.