
Patient's Name

Patient's Date of Birth

Minor Child Release Form

The confidentiality of our patient's medical and dental information is very important to us. We understand there may be circumstances in which another individual may need to care for your child. In order to provide medical care, we must require you to provide the following information.

Please list the names of authorized individuals who have your permission to be involved with your child's medical care. This permission will include appointments, medical decision-making, authorizing treatment, and authorization to release test results.

Parent/Guardian (1): _____ Phone: _____

Parent/Guardian (2): _____ Phone: _____

Sibling: _____ Phone: _____

(Step) Brother (Step) Sister Minor Yes No

Relative: _____ Phone: _____

Grandparent Aunt/Uncle Cousin Other: _____

Other Individual with consent: _____

Relationship: _____ Phone: _____

Name of Parent/Legal Guardian

Signature of Parent/Legal Guardian

Date

Name of Public Notary

Signature of Public Notary

Notary Stamp