Teeth 'R' Us Children's Dentistry
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Privacy Practices Acknowledgement

I have received the notice of Teeth "R" Us privacy practices and I have been provided an opportunity to review it.

Patient's Name:_____

Patient/Parent/Guardian's Signature: _____ Date: _____

Authorization for Release of Medical Information

I authorize Teeth "R" Us office to release or discuss my medical or dental information including treatments and the result of x-rays, pathology, etc.

Patient's Spouse, Name: _____

Patient's Father, Name: _____

Patient's Mother, Name: _____

Patient's relatives, Name: _____ Relation: _____

Patient/Parent/Guardian's Signature: _____Date: _____