Southern Village
PEDIATRIC DENTISTRY
Growing Healthy Smiles

Patient Name: _____

Patient Address: _____
Street City State Zip

Date of Birth: _____

I hereby authorize **DR. HARDIN** to RELEASE information to:

_____
Name of doctor, hospital or dentist RECEIVING information

Please mail/fax/email information to:

_____
Street City State Zip

(____) _____- _____
Fax number

_____
Email Address

Please send the following information: _____

Covering period of care from _____ to _____

I understand that I may revoke this consent at any time except to the extent that action has already been taken on it and it will expire within 90 days from the date below.

By releasing authorized information, Dr. Hardin is hereby relieved from all legal responsibility or liability for the release of the information described above to the extent indicated and authorized herein.

_____ _____
Date Signature of Parent

_____
Name of Parent

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