

## Consent for Release of Confidential Medical/Dental Information

I, (your name) \_\_\_\_\_, am the parent or legal guardian for (child's name) \_\_\_\_\_, born (MM/DD/YY) \_\_\_/\_\_\_/\_\_\_ hereby authorize (doctor's name) \_\_\_\_\_, to release the following:

- **Consent for Release of Confidential**
- **Medical/dental Information**
- **Summary of treatment needs**

### Records can be transferred by email to:

- **Englewood Location:** hello@kidsmilehigh.com
- **Central Park Location:** smile@kidsmilehigh.com
- **Thornton:** thornton@kidsmilehigh.com

This consent is given voluntarily and expires in one year.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
2<sup>nd</sup> Witness if Verbal Consent

**WWW.KIDSMILEHIGH.COM**

**ENGLEWOOD / 303.779.5306**

**F** 303.779.1822 **E** hello@kidsmilehigh.com

**A** 125 Inverness Drive East., Suite 300, Englewood, CO 80112

**CENTRAL PARK / 303.399.5437**

**F** 303.399.5445 **E** smile@kidsmilehigh.com

**A** 2373 Central Park Blvd., Suite 305, Denver, CO 80238

**THORNTON / 720.629.9969**

**F** 303.451.6101 **E** thornton@kidsmilehigh.com

**A** 7375 E 128th Ave, Thornton, CO 80602