A. Patrick Smithwick III, DDS
Board Certified Pediatric Dentist

Roger J. Castro, DDS
Board Certified Pediatric Dentist

Meredith M. Ghivizzani, DMD
Board Eligible Pediatric Dentist

KIDS MILE HIGH
PEDIATRIC DENTISTRY
ORTHODONTICS

# 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)___/___/___ hearby 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 | 2nd Witness if Verbal Consent