



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

2nd 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