

Wilmington Dental Care
General Dentistry for Youth
first tooth through age 20

CONSENT FOR USE AND DISCLOSURE
OF HEALTH INFORMATION

Please list the names of all the children you make health care decisions for at this clinic:

If you would like any other person to have access to your child's health information, or if someone other than yourself will be bringing the child to the clinic, please list their name and relationship to the child below:

I, _____ AUTHORIZE THE PERSONS NAMED ABOVE TO BRING MY CHILD TO THEIR DENTAL APPOINTMENTS AND TO MAKE ANY DENTAL TREATMENT AND EMERGENCY CARE DECISIONS NECESSARY.

Printed Name of Parent/Legal Guardian

X _____
Signature of Parent/Legal Guardian

Dr. Rafael Rivera Jr., DDS, PLLC