Frank C. Pettinato, D.D.S., P.A. **Erika Pettinato, D.M.D., M.S.** **Tierney Pettinato, D.M.D.**

PATIENT AUTHORIZATION FORM

This form MUST be completed for us to be able to speak to anyone other than yourself, or as necessary in coordinating and providing care for your child, your insurance company, or as required by law.

Patients Name:_____ Date of Birth:_____

I, _____, hereby authorize Frank C. Pettinato, D.D.S., P.A. and any Associates to discuss information described below with the authorized people listed below. I also give my permission for the authorized people to sign my child(ren) chart(s) for these visits, both Health History form and any treatment consent forms needed for these visits, as well as make treatment and financial decisions in my absence. **(By signing this form, I understand that I assume full responsibility for their decisions.)**

The Information we discuss at these appointments are listed below, but not limited to these:

- Health History
- Medical Changes
- Cavities / Broken Teeth
- Referrals to other Specialist
- How to Brush and Floss
- Sealants
- Radiographs
- Impacted Teeth
- Fluoride (In Office and Rx)
- Oral Hygiene Instructions
- Treatment Recommended
- Nitrous Oxide (Happy Gas)
- Date of Birth
- Consent Forms
- Treatment Options

To whom can we release this information or speak to about your child's dental care and financial information?

(ANYONE WHO MAY BRING YOUR CHILD TO A DENTAL APPOINTMENT)

Person's Name	**Relationship to Patient**
_____	_____
_____	_____
_____	_____
_____	_____

This authorization shall remain in effect from the signed date below until: (Please check one)

☐ Until I revoke my current authorization in writing ☐ On the Patient's 18th Birthday

I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting your office in writing at the address above, made Attention: Privacy Officer.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPPA.

Patient's or Guardian's Signature: _____ Date: _____

Patient's or Guardian's Name (Please Print):_____

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Denying Release of Information: (SIGN HERE ONLY IF THERE IS NO ONE OTHER THAN BIOLOGICAL PARENTS BRINGING CHILD(REN). IF THIS FORM IS DENIED, NO ONE WILL BE AUTHORIZED TO BRING YOUR CHILD(REN).)

I, _____, do not give my permission to release my information to anyone other than a provider necessary for providing care for your child(ren), my insurance company, or as required by law. I understand that I may change this form at anytime, as long as I do so in writing.

Patient's or Guardian's Signature: _____ Date: _____