Transfer of Authorization for Dental

At First Impressions, we understand with hectic schedules you may not always be able to accompany your child to his/her dental visit. In order to protect your rights, we ask that you fill out this form should you wish for us to share information and provide rights to another individual who has brought your child to their dental appointment.

Patient _____ DOB _____

- ◯ Dental/medical/insurance/scheduling rights consent should not be granted to anyone.
- ◯ As a parent/guardian of the patient, I authorize the release of all rights to schedule, modify appointment times, consent to treatment and share insurance, billing, and payment information or any other correspondence verbally we may need in order to treat your child now or in the future.
- ◯ As a parent/guardian I will provide documentation specifically in writing for each encounter we have with First Impressions S.C.

I grant rights to the following persons:

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

The above names have my permission to receive information regarding the patient listed above. This authorization to release information will remain in effect until terminated by the guardian in writing.

Parent Name_____

Parent Signature _____ Date _____

First Impressions S.C.
PEDIATRIC DENTISTRY & ORTHODONTICS