Pediatric
DENTAL SPECIALISTS, P.A.
CREATING SOMETHING TO SMILE ABOUT!

MEDICAL RELEASE AND ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Please include any/all children you are giving authorization for:

_____, a minor child born on ____/____/____,

_____, a minor child born on ____/____/____,

_____, a minor child born on ____/____/____,

_____, a minor child born on ____/____/____,

_____, a minor child born on ____/____/____,

_____, a minor child born on ____/____/____,

I, _____, am giving my permission to Pediatric Dental Specialists, PA
Parent / Legal Guardian (please print)

and my child(ren)'s Health Care Provider(s) to communicate and exchange health care information as it relates to their health and dental needs.

I understand I can receive a written copy of this office's Notice of Privacy Practices at my request.

_____ _____
Signature of Parent or Guardian Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

2921 N FM 1417 (Heritage Parkway) Suite 100 Sherman, TX 75092 (903) 892-1200 (800) 362-9078 Fax: (903)813-1581
www.shermankidsdentists.com