



I (parent or legal guardian) \_\_\_\_\_  
(print parent or legal guardian's first and last name)

Authorize \_\_\_\_\_  
(print first and last name of authorized person(s) and relationship to patient)

**To make decisions for my child(ren)**

_____	_____
(child's first and last name)	(child's date of birth)
_____	_____
(child's first and last name)	(child's date of birth)
_____	_____
(child's first and last name)	(child's date of birth)
_____	_____
(child's first and last name)	(child's date of birth)

**I can be reached at the following number during my child's dental appointment**

_____	_____
(primary telephone number)	(alternate telephone number)

**Additional comments:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ (Signature of parent or legal guardian) \_\_\_\_\_ (date)

A photocopy or fax copy of this release is as valid as the original. This release form is valid for 6 months from the signed date.

**This form may be sent to Sunnyside Dentistry for Children via fax number 503-826-5196 or emailed to [info@sunnykids123.com](mailto:info@sunnykids123.com)**