# Consent to Release Information

I grant permission for the person(s) listed below (other than the parent/legal guardian) to have access to any and all of my child's medical and financial information that pertains to his/her care from the doctors in this group. This includes, but not limited to, appointment times, his/her doctor's plans for dental/orthodontic care, financial information ect. This consent can be revoked at anytime by submitting to Pediatric Dentistry & Orthodontics Collective a written request to terminate this consent.

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| Name | Relationship to child |
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| **PARENT/LEGAL GUARDIAN SIGNATURE** | **DATE** |