KidsFirst Dental

2121 Midpoint Dr. Fort Collins CO 80525

RELEASE OF CONSENT FOR TREATMENT

I understand that by signing this form I consent to the following:

I release consent to the individuals listed below:

Allow the person(s) listed below to act in the place of a parent or guardian (in loco parentis) for the children listed below in respect of any circumstances, including any accident or illness, which may necessitate medical treatment, including dental treatment, and on my behalf to authorize any such treatment or surgery which they, in their sole discretion, (which discretion shall not be unreasonably exercised), may deem necessary. Medical treatment for the Child or children may also include dental surgery, x-rays, anesthetic and medication provided any such treatment is performed by a duly licensed practitioner or qualified staff members. I hereby accept full liability for all costs incurred through such dental/medical treatment for the children listed below. I also permit changes in my child's treatment and information to be left with these individual(s).

Treicuse consent to the man	riadais listea s	CIOW.		
Name				
Address				
City	State	Zip		
Phone number				
Name				
Address				
City	State	Zip		
Phone number				
Consent pertains to the follo	wing children	<u>:</u>		
-			Date of Birth:	
			Date of Birth:	
			Date of Birth:	
			Date of Birth:	
I understand that besides parer person/persons listed above.	nts or legal guar	dians we will be	unable to release ANY information to anyone other th	ian the
My consent is freely given. I un disclosures given in reliance on		•	consent at anytime if that revocation is in writing, but sible.	any
Parent or Legal Guardian's name:			Contact number:	
Parent/Guardian Signature: X			Today's date:	

If more room is needed, please use back of this form.