LAHAIR & GALLAGHER
PEDIATRIC DENTISTRY, LLC
Saving the world one tooth at a time

MATTHEW LAHAIR, DMD

F. EDWARD GALLAGHER, DMD

AUTHORIZATION TO RELEASE INFORMATION

DATE: _____

I, _____ give my permission to Drs. Lahair, Gallagher, and staff to discuss treatment provided and treatment recommended with the persons listed below until such time as I notify Drs. Lahair, Gallagher, and staff in writing that I am rescinding this authorization:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signed: _____

DENTAL HEALTHCARE PROXY

Date: _____

I, _____ parent or legal guardian, authorizes _____ to consent to treatment for all dental procedures for_____ (name/names of children). This proxy shall remain in force until such time as I rescind it.

Signed: _____

Legal relationship to patient: _____