MURPHY ORAL & MAXILLOFACIAL SURGERY
ARIC A. MURPHY, DDS, MD

RELEASE OF CONSENT FOR TREATMENT

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

Allow the person(s) listed below to act in the place of a parent or guardian (in loco parentis) for the child(ren) 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 child(ren) listed below.** I also permit changes to my child(ren)'s treatment and information to be left with these individual(s).

I release consent to the individuals listed below:

Name_____ Relationship to child(ren)_____

Address_____

City_____ State_____ Zip_____

Phone number_____

Name_____ Relationship to child(ren)_____

Address_____

City_____ State_____ Zip_____

Phone number_____

Consent pertains to the following children:
Child's Name(s): _____ Date of Birth: _____
Child's Name(s): _____ Date of Birth: _____

I understand that besides parents or legal guardians we will be unable to release ANY information to anyone other than the person/persons listed above. My consent is freely given. I understand that I may revoke this consent at any time if that revocation is in writing, but any disclosures given in reliance on this prior consent will be permissible.

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