Fort Worth Children's Dentistry

*Dentistry for Children and Teenagers*

Date: _____

Drs. Jack Morrow, Drew Jamison, and/or Nelson Beville:

I (We) _____ parent(s) of _____ authorize
**(Parent/Guardian)** **(Patient/Child)**

that the individuals designated below are hereby authorized to access or receive information about my child's healthcare from this practice or participate in treatment related decisions. Anyone not specifically named below is prohibited.

_____ _____

_____ _____

_____ _____

It is understood that this authorization is valid for twelve months from the date, unless sooner terminated.

I may be reached at _____ if you have any questions.
**(Phone Number)**

Signature: _____

**Drew Jamison, DDS**
*Diplomate of the American Board of Pediatric Dentistry*

**Jack W. Morrow, DDS, MSD**
*Diplomate of the American Board of Pediatric Dentistry*

**R. Nelson Beville, III, DDS**
*Member of the American Academy of Pediatric Dentistry*

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