Date ____________________

I hereby authorize:

Doctor: ____________________________________
Address: ___________________________________
____

To release to:

Melissa M. Beaudet-Uy, D.D.S.
76-6225 Kuakini Hwy Ste. A-106
Kailua-Kona, Hi 96740
Ph: (808)329-7351
Fx: (808)334-0055
Email: beaudetdds@gmail.com

Information pertaining to the care and treatment of:

Patient's name: ______________________________
Birth date: __________________________________

Signature of parent or legal guardian:

Print Name: ____________________________________
Relationship to patient: ___________________________
Signature: ______________________________________