Date ____________________

I hereby authorize:

Melissa M. Beaudet-Uy, D.D.S.
76-6225 Kuakini Hwy Ste. A-106
Kailua-Kona, Hi 96740

To release to:

Name____________________________________
Address___________________________________
____
Phone ___________________________________
Email ___________________________________

Information pertaining to the care and treatment of:

Patients name ______________________________
Birth date__________________________________

Signature of parent or legal guardian:

Name____________________________________
Relationship to patient_______________________