A. Patrick Smithwick III, DDS
Board Certified Pediatric Dentist

Roger J. Castro, DDS
Board Certified Pediatric Dentist

KIDS MILE HIGH
PEDIATRIC DENTISTRY
ORTHODONTICS

Consent for Release of Confidential Medical/Dental Information

I, (your name)____, am the parent or legal guardian for (child's name) ______________________________________, born (MM/DD/YY)___/___/___ hearby authorize (doctor's name) ______________________________________, to release the following:

- **Consent for Release of Confidential**
- **Medical/dental Information**
- **Summary of treatment needs**

Records can be transferred by email to:

- **Englewood Location:** hello@kidsmilehigh.com
- **Stapleton Location:** smile@kidsmilehigh.com
- **Thornton:** thornton@kidsmilehigh.com

This consent is given voluntarily and expires in one year.

____
Parent/Guardian Signature

____
Relationship to Patient

____
Witness Signature

____
2nd Witness if Verbal Consent

ENGLEWOOD / 303.779.5306
F 303.779.1822 E hello@kidsmilehigh.com
A 125 Inverness Drive East, Suite 300, Englewood, CO 80112
@kidsmilehigh

STAPLETON / 303.399.5437
F 303.399.5445 E smile@kidsmilehigh.com
A 2373 Central Park Blvd., Suite 305, Denver, CO 80238
@kidsmilehighstapleton

THORNTON / 720.629.9969
F 303.451.6101 E thornton@kidsmilehigh.com
A 7375 E 128th Ave, Thornton, CO 80602
@kidsmilehigh