

Permission to Treat

I, _____, authorize Pat Ricalde, D.D.S., M.D., P.L. and
(Print name of legal guardian)
its personnel to provide medical services such as medical examination and treatment, as
they deem best for the child's physical or mental welfare.

(Print child's name) (Date of birth) (Social Security #)

I authorize the following person/people to bring my child in for treatment and/or to
discuss any necessary treatments, medications and to even authorize any tests or labs that
are necessary up to and including admission to the hospital.

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

****All of the above will provide identification to be placed in the patients chart.**

I agree that unless I give specific instructions otherwise, medical information regarding
my child's diagnosis and treatment may be released to biological parents, step parents,
referring physicians and other practitioners, and my insurance company.

I have been advised and understand the Notice of Privacy Practices and the Financial
Policies of Pat Ricalde, D.D.S., M.D., P.L.

Signature / Legal Gaurdian *Date*

Relationship to patient: _____

RELEASE FOR USE OF PHOTOS

I understand that the Pat Ricalde, MD, DDS, PL may take digital photographs, and other
image media of treatment during both pre-op and post-op visits. Pat Ricalde, MD, DDS,
PL may wish to use such photographs for educational, promotional, advertising, and
other purposes. This permission for release, without compensation or prior notice, would
allow Pat Ricalde, MD, DDS, PL to use photographs in its printed publications, during
presentations, and otherwise.