# PRIVATE HEALTH INFORMATION AUTHORIZATION FORM DISPLAY OF "NO CAVITY CLUB PHOTOS"

Little Fish Dental
6560 Lonetree Blvd Suite#102
Rocklin, CA 95765
916-435-9799

I authorize my provider to disclose the following private information to the entity identified and for the purpose listed below.

Description of the specific information to be used or disclosed:

Displaying child's picture on our **"No Cavity Club Board"**

_____

_____

**Recipient of the information:**

**Name:** Little Fish Dental
**Address**: 6560 Lonetree Blvd Suite #102
Rocklin, CA 95765

- ○ If this box is checked you are authorizing Little Fish Dental to display your child's picture on our "No Cavity Club Board".

- ○ If this box is checked you would NOT like your child's picture displayed on our "No Cavity Club Board".

**Patient Name:** _____

**Signature:** _____

**Relationship to Patient:** _____

**Date:** _____