Designation for Another Person to Consent for Treatment of Minor Child

APPOINTMENT DATE _____

Should a parent or guardian not be able to accompany the Minor Child to his/her appointment, please fill out the information below. Please have medical history paperwork filled out in advance, or the person bringing your Minor Child will be responsible for providing accurate information about any medical problems and changes, allergies, current medications, and dental concerns.

We require a copy of a government issued form of ID for the Parent/Legal Guardian (please attach to this form) and the Designated Adult

MINOR CHILD

Full Legal Name: _____

Home Address: _____

Date of Birth: _____

PARENT/LEGAL GUARDIAN

Full Legal Name: _____

Relationship to Minor Child: _____

Home Address: _____

Telephone Number: _____

DESIGNATED ADULT (non-patient sibling, and 18 years or older)

The Designated Adult must physically remain in the office at all times from the time of checking the patient in until appointment is completed and patient is checked-out

Full Legal Name: _____

Relationship to Minor Child: _____

Home Address: _____

Telephone Number: _____

I, _____, am the parent or legal guardian of _____ ("Minor Child"), who is not emancipated and under age 18. By signing this form, I authorize _____ ("Designated Adult") to fully disclose and discuss Minor Child's personal medical history, to consent to or refuse any dental care or treatment for Minor Child that is recommended by the Pediatric Dental Team dental provider, and make any medical decisions that are required. I understand that my authorization is given prior to any dental treatment ro recommendation. However, this authorization empowers Designated Adult with authority to exercise his/her best judgment upon the advice from the Pediatric Dental Team dental provider, and consent to or refuse any dental care or treatment for Minor Child.

I retain the responsibility for all charges by the Pediatric Dental Team resulting from Designated Adult's consent. I release the Pediatric Dental Team providers and staff from any liability arising from this form and Designated Adult's consent to or refusal of treatment for Minor Child.

I understand that the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other applicable State laws govern the disclosure of Protected Health Information (PHI). **I authorize the Pediatric Dental Team to disclose Minor Child's PHI to Designated Adult.**

My authorization is only effective for the appointment date written above.

Parent/Legal Guardian Signature: _____

Date: _____

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