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PARENTAL CONSENT FOR TREATMENT BY PROXY FOR A MINOR CHILD

(ACCOMPANIED BY SOMEONE OTHER THAN A PARENT OR LEGAL GUARDIAN)

I, the undersigned parent or legal guardian of _____ ,
(Child's Name)
a minor child whose date of birth is _____, by this written authorization do hereby authorize and indicate by consent and delegation of my authority for the dental evaluation, diagnosis and treatment of my child listed above to _____,
(Name of Parental Authorized Individual)
_____.
(Authorized Individual's Relationship to the Patient)

I understand certain patient health information (PHI) may be disclosed at the time of service and give my consent for disclosure of PHI to: _____, for the purpose
(Name of Parental Authorized Individual)
of evaluation and treatment. I understand that this consent is valid until it is revoked by me or revoked by the dentist, and that I may revoke this consent at any time by giving written notice of my desire to do so to the dentist.

By signing below, I agree to and hereby authorize the above mentioned actions by _____ until such time as I revoke this authorization and consent in writing.
(Name of Parental Authorized Individual)

Signature: _____ Date: _____

Relationship to Patient: _____