Pediatric (17 years and younger) Compound Authorization of Patient

Patient Name: _____

If you would like any other person to have access to your child's health information, or if someone other than yourself will be bringing your child to their appointments, please list their name and relationship to your child:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name:_____ Relationship: _____

I authorize the person/persons named above to bring my child to their dental appointments and to make any dental treatment and emergency care decisions necessary. I authorize the person/persons named above to sign treatment consents if required. I understand I am ultimately responsible for any treatment fees and outstanding balances.

I understand that it is recommended that an adult remain on the premises while my child is receiving treatment.

I understand that this form is valid until I request to make any changes. I understand that biological parents are always allowed to consent to treatment (unless we are informed otherwise).

Signature _____ Date _____