AUTHORIZATION FOR MINOR CHILD ACCOMPANY

Child(ren)'s full name(s): _____

Date of Birth (s): _____ , _____ , _____

I, _____ give _____
(Parent or Legal Guardian) **(Authorized Person's Full Name)**

Permission to accompany my child to the office of Sweet Peadiatric Dentistry for dental appointments.

I also give permission to the above stated authorized person to make necessary decisions regarding dental treatment for my child including, but not limited to:

- The consent for this authorized person to accompany my child for exams, dental cleanings, or restorative treatment and to discuss post-operative instructions.
- The consent of Sweet Peadiatric Dentistry to discuss finances (treatment charges, account balances, next visit charges) with this authorized person.
- The consent for this authorized person to discuss my child's dental findings, future dental treatment needs, and any pertinent personal health information (PHI).

As the parent or legal guardian, I understand that I must present to the office, in person, to sign any treatment plans or informed consents before any restorative procedures or invasive dental treatment can be performed for my child. I further understand that it is my responsibility to provide payment or a source of payment on the day that services are rendered, even when this authorized person brings the child, or no treatment will be performed for my child.

_____

(Signature of Parent or Legal Guardian) **(Date)**

_____

(Witness) **(Date)**