AUTHORIZATION OF TREATMENT DURING PARENTAL ABSENCE

Child's Name: _____ Date of Birth: _____

Child's Name: _____ Date of Birth: _____

Child's Name: _____ Date of Birth: _____

Authorized Caregiver's Information

Caregiver's Name: _____

Relationship to patient(s): _____

The above named caregiver shall be authorized to consent for all dental treatment, for the above named child(ren), which may be required during my absence. The above caregiver is authorized to receive any information and/or instructions regarding my child(ren)'s dental treatment. I agree to pay for all services provided to my child(ren) that the caregiver authorized. Payment is expected when services are rendered.

If circumstances permit and/or if Hancock Village Dental needs to contact me,

Please contact me at the following telephone number: _____

This authorization shall be effective until:

One (1) year from date signed

OR

Until _____ (list Month, Day, Year)

This consent serves as permission for treatment by Hancock Village Dental for the above named child(ren).

_____ _____ _____

Parent/Legal Guardian Name (Printed) Parent/Legal Guardian Signature Date

☐ Parent ☐ Legal Guardian

****Note: Consents are NOT required in emergency situations.****