



Dentistry for Children and Teenagers

Consent to Authorize Treatment

If anyone other than the mother, father, or legal guardian of our patient brings him/her to our office for dental care or treatment we must have written authorization. This authorization form is required for reason pertaining to HIPAA, as well as the safety of your child. Your understanding and cooperation is greatly appreciated.

You may authorize other persons to bring your child to our office and authorize dental care and treatment by filling out the following form.

Patient Name: _____

I, _____ hereby give permission to _____ to bring my child(ren) to Smiles for Kids, West for dental examinations, cleanings and treatment.

This authorization shall be in effect

- For the date of _____
- Until revoked by me

Signature: _____ Date: _____

• Specializing in Pediatric Dentistry •

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