Practical Approach
Pediatrics and Pediatric Dentistry

CONSENT TO SEE PATIENT WITHOUT PARENT PRESENT

Patient Name: _____ DOB: _____

I hereby authorize _____DL#_____

(Relationship)_____to bring my child to his/her appointments if I am unable to attend. I understand that medical, dental and financial information (will be given) as well as emergency decisions will be made on my behalf.

EXPIRATION DATE OF AUTHORIZATON

This authorization is effective unless revoked or terminated in writing by the patients legal guardian.

RIGHT TO TERMINATE OR REVOKE AUTHORIZATION

You may revoke or terminate this authorization by submitting a written revocation to the practice. You should contact the Privacy Officer to terminate this authorization.

POTENTIAL FOR RE-DISCLOSURE

Information used or disclosed under this authorization may be subject to re-disclosure and may no longer be protected by federal or state law.

I,_____have read and considered the contents of this consent form and your Notice of Privacy Practices. I understand that by signing this consent form, I am giving my consent to your use and disclosure of my child's protected health information to carry out treatment, payment activities and health care operations.

Signature_____ Date_____