myKIDSdds
Dentistry for Children & Orthodontics

Parental Authorization for Care Form

We recognize that the need may arise for someone other than the parent or legal guardian/primary caregiver to bring your child to their appointment(s). In an effort to protect your child's personal health information (PHI) and deliver uninterrupted care, please complete this form. This will allow the person(s) you designate the authority to approve necessary x-rays, their cost and acknowledge treatment plans recommended by the doctor in behalf of your child/children. It will become part of your child's chart and remain in effect until you notify us of other designations.

Patient's Name _____
Last First Initial Date of Birth

Patient's Name _____
Last First Initial Date of Birth

Patient's Name _____
Last First Initial Date of Birth

I, _____, signify that I am the parent/legal for the patient.
(print name)

Address: _____

Phone #: _____

I give consent to the following to discuss and make decisions about my child's dental care with the myKIDSdds staff:

Name: _____ Phone #: _____ Relation: _____

Name: _____ Phone #: _____ Relation: _____

Name: _____ Phone #: _____ Relation: _____

Parent/Legal Guardian's Signature: _____ Date: _____