growing smiles
PEDIATRIC DENTISTRY
Carisse Corns DDS, Board Certified Pediatric Dentist

POWER OF CONSENT

(Step parents also need authorization)

I,_____, the parent or legal guardian of
(Name of Parent or Legal Guardian)

_____, authorize the individuals
(Name of Child/Children)

below to accompany my child/children to visits and consent to necessary dental exams and/or treatment and disclosure of dental information regarding the initial and/or follow-up care of my child/children during the visits.

_____ _____
(Name of person Bringing child other than parent) (Relationship to child)

_____ _____
(Name of person Bringing child other than parent) (Relationship to child)

_____ _____
(Name of person Bringing child other than parent) (Relationship to child)

The person(s) named above may consent to the examinations and treatment for my child.

This authorization/consent is effective on this,___ day of_____, 20___.
This Document is effective until revoked by me in writing to Growing Smiles Pediatric Dentistry, PC.

_____ _____
(Signature of Parent/Legal Guardian) (Printed Name of Parent/Legal Guardian)