Authorization to Treat a Minor Patient

In the event that a parent or legal guardian is unable to accompany the child to an appointment, you may use this form to give another ADULT permission to bring your child to our office. A Legal guardian needs to sign and provide authorization:

I/We (name of parent/guardian) ______________________________ , the parent and legal guardian of

(child's name)____________________________________ , hereby authorize (name of Adult accompanying your

child)_____________________________________ to accompany my above named child to office

visits with Islands Pediatric Dentistry and to consent to the examination and/or treatment of

my child during the visit.

This authorization:

- Is effective only on ______________________________
- Is effective from ________________ to ______________
- Is effective until revoked by me/us in writing

I reserve the right to revoke this authorization at any time by writing to Islands Pediatric Dentistry at 1425 W Elliot Rd. Suite A101, Gilbert AZ 85233.

____ __________________________

Signature of Parent/Guardian Date

____ __________________________

Signature of Parent/Guardian Date

Sworn to and subscribed before me this
______day of ____________, 20_____.

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NOTARY PUBLIC
My commission expires: