# AUTHORIZATION FOR MINOR CHILD ACCOMPANIMENT

**I give the authorized listed person(s) permission to accompany my child to the office of Grins Pediatric Dentistry for dental appointments.**
**I also give permission to the authorized listed person(s) to make necessary decisions regarding dental treatment for my child including, but not limited to:**

- The consent to accompany my child for exams, dental cleanings or restorative treatment and to discuss post-operative instructions.
- The consent of Grins Pediatric Dentistry to discuss finances (treatment charges, account balances, next visit charges) with this authorized person.
- The consent to discuss my child's dental findings, future dental treatment needs and any pertinent personal health information (PHI).

As the parent or legal guardian, I understand that I must sign any treatment plans or informed consents before any restorative procedures or invasive dental treatment can be performed for my child. I further understand that it is my responsibility to provide payment or a source of payment on the day that services are rendered, even when this authorized person brings the child, or no treatment will be performed for my child.

| **Name of Authorized Persons** | **Relationship to Patient** |
| --- | --- |
| ______________________________ | ______________________ |
| ______________________________ | ______________________ |
| ______________________________ | ______________________ |
| ______________________________ | ______________________ |

_________________________________ ____________
Parent/Guardian Signature Date

_________________________________
Parent/Guardian Printed Name