



HEALTH INFORMATION ACCESS

We understand that at times it is not possible for the parent/legal guardian of a child to bring him/her in for a scheduled appointment or for emergency treatment. You may give permission for others to bring your child by filling out this form. If you leave this section blank, ONLY the parent/legal guardian will be allowed to consent for treatment.

I, _____, as parent/legal guardian of _____, give permission to R & R Dental Specialists, PC to share my child's protected health information with the individuals I list below. Moreover, I give permission for the listed to consent for the treatment of my child if necessary.

_____ (Name)	_____ (Relationship)	_____ (Cell Number)
_____ (Name)	_____ (Relationship)	_____ (Cell Number)
_____ (Name)	_____ (Relationship)	_____ (Cell Number)

When obtaining dental treatment, I will make sure the above individual(s) are informed of my child's medical history and can answer all questions required for safe dental treatment. In addition, I understand that treatment changes may occur for a variety of reasons. I understand and agree that any treatment plan that may have been explained to me is subject to change and in some cases will change the fees quoted initially to me. The persons listed above have the right to consent to these charges and changes.

Lastly, I will make arrangements for the above individual(s) to bring any necessary insurance forms and/or payment for services rendered at each visit.

I attest I understand the above information on this page and with my signature give my consent to enforce this document.

Parent's Signature

Date

Patient's Name

Patient's Date of Birth