



**AUTHORIZATION FOR TREATMENT OF A MINOR**  
**Please include any/all children you are authorizing consent for:**

I, \_\_\_\_\_, parent(s)/legal guardian(s) of:

\_\_\_\_\_ , a minor child born on \_\_\_\_/\_\_\_\_/\_\_\_\_,

\_\_\_\_\_ , a minor child born on \_\_\_\_/\_\_\_\_/\_\_\_\_,

\_\_\_\_\_ , a minor child born on \_\_\_\_/\_\_\_\_/\_\_\_\_,

\_\_\_\_\_ , a minor child born on \_\_\_\_/\_\_\_\_/\_\_\_\_,

\_\_\_\_\_ , a minor child born on \_\_\_\_/\_\_\_\_/\_\_\_\_,

\_\_\_\_\_ , a minor child born on \_\_\_\_/\_\_\_\_/\_\_\_\_,

Hereby authorize other than legal parent / guardian:

_____	_____	_____	_____
(Name)	(Relationship to child)	(Name)	(Relationship to child)
_____	_____	_____	_____
(Name)	(Relationship to child)	(Name)	(Relationship to child)

to give consent for the dental treatment of the above named child(ren) for any dental condition that he/she may encounter; or to bring the child(ren) to PDS for routine checkups and associated procedures deemed necessary by PDS. I also authorize the dentist, hygienists, and staff at PDS to give information to the individual(s) named above regarding the diagnosis and plan of treatment, or any information necessary for the care of the above named child(ren).

- I hereby release PDS of any liability regarding release of this information on the above named child(ren).
- I understand that if someone other than the above listed on this form brings my child(ren) to the dental appointment, my appointment will be rescheduled for another time.
- I understand that only the above listed have permission to make decisions regarding my child(ren)'s dental treatment, and it is my or other legal guardian's responsibility to notify PDS of any desired changes.
- I understand changes can be made by a parent or legal guardian at anytime by filling out a new authorization for treatment of a minor, as these changes are not considered addendums to the existing form.
- I understand that even though I have authorized the above named to make treatment decisions regarding the above named child(ren), I will be financially responsible for this family account.

_____	_____	_____	_____
Parent/Legal guardian	Date	Parent/Legal guardian	Date

Please INITIAL if applicable:

\_\_\_\_\_ I hereby authorize my child (ages 16 and above) to receive dental treatment (e.g. dental checkup, emergency visits, x-rays, cleaning, fluoride) without an authorized person accompanying him/her.