Authorization by Patient, Parent or Legal Representative for Another Person to Bring Child to Physician's Office and Access to Protected Health Information (PHI).

Patient's Name: _____ Date of Birth: _____

I hereby provide permission for the following persons to bring my child to the office. If the patient is 18 years of age or older, the patient must sign the form allowing a parent or legal guardian to have access to their PHI.

Name **Relationship to Patient**

_____

_____

_____

_____

For patients 16 years and older ONLY:

Yes____ NO____ Patient listed above may present and be treated unaccompanied by an adult. Financial and Insurance arrangements will be made prior to scheduled appointment.

I understand that when the person(s) identified above takes my child for preventative services or a dental problem, that this person may need to provide consent for my child to receive dental treatment of my child. I hereby authorize the person(s) listed above to provide consent for the provision of dental services to my child by the dental providers of Bay Pediatric Dentistry.

_____ _____

Name of patient, parent or Legal Guardian Signature

_____ _____

Relationship to Patient Date

We will continue to rely on the information on this form unless you request changes. It is your responsibility to immediately notify Bay Pediatric Dentistry of divorce, legal separation, change in custody arrangement, or any other circumstance, which may alter this authorization.

To revoke or alter this authorization, please send a written request with a copy of this form to the address below. A copy is in the patient's records for reference.

Bay Pediatric Dentistry 660 Dover Center Rd. Ste. 17 Bay Village, OH 44140