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IN ORDER TO PROVIDE DENTAL CARE FOR A PATIENT, WE REQUIRE THE PERMISSION OF A PARENT &/OR LEGAL GUARDIAN. IF YOU ARE UNABLE TO BE PRESENT FOR AN APPOINTMENT, WE REQUIRE YOUR WRITTEN AUTHORITY TO RELY ON YOUR DESIGNATED PERSON(S) TO ESCORT YOUR CHILD FOR DENTAL CARE. THOSE DESIGNATED INDIVIDUALS THAT ESCORT YOUR CHILD WILL BE ELIGIBLE FOR PATIENT INFORMATION AS DESCRIBED IN THE NOTICE OF PATIENT PRIVACY/PRIVATE HEALTH INFORMAITON ACKNOWLEDGEMENT.

PLEASE COMPLETE THIS FORM TO DESIGNATE ESCORT(S) FOR YOUR CHILD'S DENTAL CARE.

Patient Name: _____ DOB: _____

As the parent/legal guardian of the above named patient, I give authorization for Dr. Amanda Velazquez to accept the permission of the following person(s) in my absence for dental care of my minor child. I hold harmless Dr. Amanda Velazquez and Suncoast Pediatric Dentistry, PLC in using this consent for treatment and acknowledge that this consent is valid until revoked by me in writing. I am responsible for all charges in connection with treatment rendered. With this consent Suncoast Pediatric Dentistry, PCL is authorized to share medical &/or billing information with these same individuals. Furthermore, I authorize Dr. Amanda Velazquez and her staff to examine the patient, clean his/her teeth, take dental radiographs, perform any necessary treatment, administer local anesthetic or medications, apply topical fluoride, obtain study models or other necessary records in my absence as authorized by the below person(s).

I authorize _____, relationship _____

I authorize _____, relationship _____

I authorize _____, relationship _____

I authorize _____, relationship _____

Legal guardian:

_____/_____

Signature Print Name

Date: _____ Relationship to Patient: _____

Contact Number: _____