

HENDRICKS PEDIATRIC DENTISTRY  
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## Patient/Guardian Authorization to Disclose Protected Health Information to Others and Consent to Treat

Patient Name: \_\_\_\_\_ Birthdate \_\_\_\_\_

Patient Name: \_\_\_\_\_ Birthdate \_\_\_\_\_

Patient Name: \_\_\_\_\_ Birthdate \_\_\_\_\_

Patient Name: \_\_\_\_\_ Birthdate \_\_\_\_\_

Patient Name: \_\_\_\_\_ Birthdate \_\_\_\_\_

Patient Name: \_\_\_\_\_ Birthdate \_\_\_\_\_

Patient Name: \_\_\_\_\_ Birthdate \_\_\_\_\_

I give permission for protected health information to be disclosed to the following person(s). They may also consent to treatment for the above named patients. This includes scheduling appointments, bringing them to appointments, signing treatment consents and approving use of Nitrous Oxide (laughing gas).

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Printed name of legal guardian \_\_\_\_\_

I hereby declare that I am the legal guardian of above named patient(s).

Signature of legal guardian \_\_\_\_\_

Relationship \_\_\_\_\_ Date \_\_\_\_\_

**\*Please provide any legal documentation showing assignment of relationship to patient(s).**

**Note:** If at any time you want to update this information it is your responsibility to ask for a new form. The most current form will be honored.