AUTHORIZATION TO ACCOMPANY A MINOR

There may be times when you are unable to bring your child to the office for an appointment and need to rely on a family member or friend. We understand these circumstances do arise so we ask for written authorization to allow any person(s) other than a parent/legal guardian to accompany your child(ren).

I, __________________________________(Parent/Legal Guardian), give the person(s) listed below permission to bring my child to appointment(s) at Durham Pediatric Dentistry and Orthodontics and to discuss and share dental and personal health information about my child(ren). I further authorize said person(s) to view all necessary dental records and make pediatric dental and orthodontic care decisions as recommended, presented and discussed by Dr. John Christensen, Dr. Robert Christensen or their staff. This authorization will stay in effect until rescinded by Parent/Guardian.

Child's Name: ____________________________________ DOB: _______________

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Name of Person (with consent to Accompany Minor) Relationship

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____ _____________________

Name of Person (with consent to Accompany Minor) Relationship

____ _____________________

Signature (Parent / Guardian) **Date**