Designation of Representative or
Consent to Dental Care for a Minor Child/Dependent Adult

This form is to be use when the parent/legal guardian cannot accompany a minor child (under 18 years of age) or dependent adult to an appointment, and they need to designate an adult to represent the parent or guardian at the appointment. **This authorization must be brought to the appointment by the dependent or accompanying adult.**

RELEASE STATEMENT

I cannot accompany my dependent, _____ to the scheduled dental appointment today.
(Dependent's full name)

I hereby give my consent for the following individual(s) over the age of 18 to be the guardian to accompany my minor child/dependent to their dental appointment(s) and to have access to any medical records needed in order to accompany my minor child/dependent:

_____ _____
Designated Individual Relationship to Patient

_____ _____
Designated Individual Relationship to Patient

The dental provider may reach me **during the appointment** time at the following contact number, should they need to discuss any treatment needs or changes:

Phone Number: (_____) _____ - _____

I understand that a medical history may be taken and a comprehensive dental examination may be performed. Necessary procedures such as x-rays, cleanings, and dental fillings may be done if needed. I accept responsibility for all costs related to such treatment that may be incurred during the visit(s) I am not present for.

This form will be active for six months and cannot exceed that time frame. Should the legal guardian need to designate an individual for appointments beyond 6 months from the date of this form, a new Designation form will need to be completed.

Please specify below your intent for this Designation Form:

☐ To be active for only the appointment date(s) signified here: _____

☐ To be active for 6 months from the date this form was completed.

At that time, no express revocation shall be needed to terminate my consent, but understand that I may revoke this consent at any time by sending written notice to the **Dental Connections, Inc., 1111 9th Street, Ste. 190, Des Moines, Iowa 50314**. I understand that any release which was made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. I understand that I may review the disclosed information by contacting Dental Connections, Inc..

_____ _____
Parent/Legal Guardian Name (Print) Parent/Legal Guardian (Signature)

_____ _____
Date Relationship to Patient