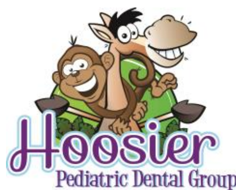

Transfer of Authority for Treatment Consent by Parent/Guardian

This document certifies that I, ________________________ am the legal parent and/or guardian of the following minor: ________________________________("the Patient"). I through this consent give permission to, request and authorize the following "Person (s)": ____ to transport the Patient to/from Hoosier Pediatric Dental Group, LLC office for examination and treatment; to accompany the Patient while at Hoosier Pediatric Dental Group, LLC; and to make any and all additional decisions as needed regarding consent for the Patient's treatment. I designate and formally recognize the name Person(s) to make treatment decisions on my behalf for the Patient. I request that the name Person(s) represent me as the parent/guardian at my request and are involved in the Patient's care and treatment. I give permission for the name Person (s) to receive the Patient's health information and records, including any privileged or confidential information. I have been informed of the necessary examination and treatment for the Patient. I have received adequate consent information and I understand the diagnosis, reason for the procedures as well as risks, benefits and options to the proposed treatment. I have been informed of different scenario outcomes ranging from a successful treatment, failed treatment, and if no treatment is done. I request, consent, and authorize Hoosier Pediatric Dental Group, LLC to provide such examination and treatment to the Patient, including treatment of conditions which arise during such examination and treatment. However, to the extent additional consent is needed later, I authorize Hoosier Pediatric Dental Group, LLC to rely upon the Person (s) listed above to make any and all additional decisions and sign any required paperwork regarding the Patient. I understand Hoosier Pediatric Dental Group, LLC will not be held legally liable for any treatment changes or decisions made by the Person (s) listed above and that I will be liable for costs of the Patient's care consented to by the Person (s) but not covered by the Patient's dental insurance. I have been advised by Hoosier Pediatric Dental Group, LLC that it is in the Patient's best interest for the Patient's parent/guardian to be present; however, I have opted to delegate my authority to make decisions for the Patient to the Person (s) listed above. The Person (s) will accompany the Patient and acton on the Patient's behalf at my request. This form is valid for one (1) year from the date signed, and a copy is as valid as the original.

____

(Name) Print Please

____

Parent/Guardian Signature Date

____

Hoosier Pediatric Dental Group, LLC Witness Signature