



ESSENTIAL  
ENDODONTICS

**Minor Child** Full Legal Name: \_\_\_\_\_  
Home Address: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_

**Parent/Legal Guardian** Full Legal Name: \_\_\_\_\_  
Home Address: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Relationship to Minor Child: \_\_\_\_\_

**Designated Adult** Full Legal Name: \_\_\_\_\_  
Home Address: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Relationship to Minor Child: \_\_\_\_\_

I, \_\_\_\_\_, am the parent or legal guardian of \_\_\_\_\_ (“Minor Child”), who is not emancipated and under age 18. By signing this form, I authorize \_\_\_\_\_ (“Designated Adult”) to consent to or refuse any dental care or treatment for Minor Child that is recommended by Essential Endodontics dental provider. I understand that my authorization is given prior to any dental treatment or recommendation. However, this authorization empowers Designated Adult with authority to exercise his/her best judgment upon the advice of the Essential Endodontics dental provider, and consent to or refuse any dental care or treatment for Minor Child.

**I retain the responsibility for all charges by Essential Endodontics resulting from Designated Adult’s consent. I release Essential Endodontics, providers, and staff from any liability arising from this form and Designated Adult’s consent to or refusal of treatment for Minor Child.**

I understand that the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other applicable State laws govern the disclosure of Protected Health Information (PHI). **I authorize Essential Endodontics to disclose Minor Child’s PHI to Designated Adult.**

**My authorization is effective until Minor Child reaches age 18, or until I revoke my authorization in writing.**

Parent / Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Witness Signature: \_\_\_\_\_  
Notary Signature: \_\_\_\_\_

**Written Notice to Revoke Authorization**

I, \_\_\_\_\_, am the original maker of this designation form. Upon signing this Written Notice, I no longer authorize \_\_\_\_\_ (“Designated Adult”) to consent to or refuse any dental care or treatment for \_\_\_\_\_ (“Minor Child”).

Parent/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_