ESSENTIAL

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: _____