



Compound Authorization of Patient

Patient Name: _____

If you would like any other person to have access to your child's health information, or if someone other than yourself will be bringing your child to the clinic, please list their name and relationship to your child:

Name: _____ Relationship _____

Name: _____ Relationship _____

Name: _____ Relationship _____

I authorize the persons named above to bring my child to the their dental appointments and to make any dental treatment and emergency care decisions necessary.

Signature _____ Date _____

Patient or Guardian

Relationship _____