



Designation of Consent for Another to Authorize Treatment

This form must be completed by the minor's parent or legal guardian.

It is best practice to see minors with their parent or authorized guardian present. If you cannot be present at the appointment with your minor, we are legally obligated to have your written authorization before we treat your minor.

This form allows you to pre-designate adults that can accompany your minor at future visits and consent to treatment for your minor by exercising their own best judgement upon advice of Spectra Health licensed personnel.

Our clinic staff and providers reserve the right to postpone any non-urgent procedure if proper consent cannot be obtained before the time of an appointment.

Minor Patient's Information			
Minor's First Name:	MI	Minor's Last Name:	Minor's Date of Birth:

Parent / Legal Guardian Information			
Parent / Guardian First Name:	MI	Parent / Guardian Last Name:	Date of Birth:
Relationship to Minor Patient:	Parent / Guardian Phone Number:		Alternate Phone Number:
If Authorized Guardian is a representative of a government agency, please list agency name:		Government Agency Phone Number:	

Additional Parent / Legal Guardian Information			
Parent / Guardian First Name:	MI	Parent / Guardian Last Name:	Date of Birth:
Relationship to Minor Patient:	Parent / Guardian Phone Number:		Alternate Phone Number:



Minors under 14 years of age must be accompanied to appointments by a parent, authorized guardian, or designated adult.

To help us best care for your minor, please identify **any** other adult that can accompany your minor to appointments. **These individuals must be over the age of 18.**

Please complete the next section of this form to designate adults that can accompany your minor to appointments and authorize treatment on your behalf.

Other adults authorized to accompany your minor to appointments at Spectra Health			
First and Last Name	Relationship to minor	Can accompany minor to visit?	Phone
		[] yes [] no	
		[] yes [] no	
		[] yes [] no	
		[] yes [] no	

Minors over the age of 14:

If your minor is over the age of 14, can they attend appointments without you, or without an approved designated adult?

[] No [] Yes

Dental Clinic Use Only

Extraction Appointments:

Due to the irreversible nature of extractions, I understand that a parent or legal guardian must be present for all extraction appointments involving my minor child, and no other adult can be designated to authorize this treatment or attend these visits.

Minor patients between the ages of 14 and 18 **must** be accompanied at these visits.

Parent / Guardian Signature

Date

Treatment Plan Consent:

☐ I understand that dental treatment will be completed as listed on the treatment plan, I have signed separately, and that a parent or legal guardian must separately authorize the dental treatment plan.



Limitations:

Are there any limitations you would like to place on the treatment that Spectra Health may provide to your minor if you are not present at an appointment?

☐ No ☐ Yes

If yes, please describe:

Parent / Legal Guardian Consent:

In an emergency, we will provide treatment and contact you as soon as possible. Urgency will be determined by our licensed professionals. Be advised that your minor's protected health information may be shared with the person(s) you designate on this form to accompany your minor to appointments. If you do not want protected information shared with these individuals, please designate that in the limitations section above.

I have the legal right to pre-authorize Spectra Health to deliver health care to my minor, listed above. I request and authorize Spectra Health and its personnel to deliver health care to my minor, listed above. I understand that every effort will be made to obtain proper consent prior to each visit. I understand that in an emergency situation, treatment for my minor will be initiated immediately and Spectra Health personnel will contact me as soon as possible. I understand that I am providing authority to the designated adult(s) to consent to treat my minor and exercise his or her own best judgement upon the advice of licensed Spectra Health personnel. The information provided on this form is true, correct, and complete to the best of my ability.

Parent / Legal Guardian Signature

Date

Parent / Legal Guardian Printed Name