Pediatric Dental Group of Colorado

ACKNOWLEGEMENT AND CONSENT BY PARENT/GUARDIAN TO TRANSFER AUTHORITY FOR TREATMENT

I,_____certify that I am the parent and/or legal guardian of the following child:_____(the patient). I hereby give permission to, request and authorize the following person(s):_____

To transport the patient to/from whichever location of Pediatric Dental Group said appointment is scheduled at for examination and treatment; to accompany the patient while at Pediatric Dental Group; and to make any and all additional decisions as needed regarding consent for the patient's treatment. I designate and formally recognize the named person(s), stand(s) in for me as the parent/guardian of the patient at my request, are/is involved in the patient's care and treatment, and can receive the patient's health information and records, including any privileged or confidential information. I have already been advised of the necessary examination and treatment for the patient. I have received sufficient consent information explaining the diagnosis, purpose of the procedures, material risks, benefits, alternatives, likelihood of success, and prognosis if rejected. ***I hereby request, consent to and authorize Pediatric Dental Group 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 later requested, I authorize Pediatric Dental Group to rely upon the above-listed person(s), and that I will be liable for costs of the patient's care consented to by the person(s) but not covered by my Insurance or Medicaid. I have been advised by Pediatric Dental Group that is is in the patient's best interest for the patient's parent to be present; however, I have opted to delegate my decision-making authority to the person(s) listed above; who will accompany the patient and act on the patient's behalf at my request. This form is valid for (1) year from the date signed, and a copy is as valid as the original.

_____ _____ _____

Signature of Parent or Guardian **Date** **Time AM/PM**

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Pediatric Dental Group Staff Witness