Kaysville Pediatric Dental and Orthodontics
Parental/Legal Guardian Consent for Dental Treatment

The caregiver(s) named below (**OTHER THAN PARENT OR LEGAL GUARDIAN**) shall be authorized to consent for all dental treatment for my child(ren) which may be required in my absence. I also authorize the release of health care information to the listed caregiver(s). I agree to pay for all services provided to my child(ren) that the caregiver(s) authorized.

Authorized Caregiver's Information (OTHER THAN PARENT OR LEGAL GUARDIAN)

Caregiver's Name	(Relationship to patient)	Phone Number
Caregiver's Name	(Relationship to patient)	Phone Number

Children Covered Under Authorized Treatment Consent

Child's Name	Child's Name	Child's Name
Child's Name	Child's Name	Child's Name

This consent serves as permission for the above-named child(ren). This authorization shall remain in effect unless I revoke this authorization and submit it to Kaysville Pediatric Dental and Orthodontics.

Parent/Legal Guardian Signature	Date