TEMPORARY AUTHORIZATION

The purpose of this authorization is to allow an adult person 18 years of age or older, other than the parent or legal guardian, to provide informed consent for a minor child to receive dental services at Bay County Health Department Children's Dentistry Clinic. The authorized person must stay on the clinic premises throughout the dental visit.

I, _____, parent or legal guardian of Minor Child's

Name: Last_____ First_____ MI_____

Minor Child's Date of Birth: _____

Minor Child's Social Security Number: _____ hereby authorize

Last Name:_____First_____MI_____

Relationship to Child: _____, to provide informed consent for my minor child to receive dental services. I understand that proper identification* of the authorized adult named on this form is required at time the service is rendered. Types of ID accepted: pictured ID or driver's license. This adult person must stay on the premises and be available to the dentist until the visit is completed.

_____ _____

Signature of Parent or Legal Guardian **Date**

Current Address

_____

Phone Number(s) I can be reached: _____

This authorization will expire one year from date signed unless date is specified: _____.

If you have questions, please call (850) 481-4709.

*NOTE: ID will be copied on the day of service. Please have your ID ready to give the receptionist. Thank you.

Dental/Forms/Temp Auth/slm