7170 Caton Farm Rd, Suite I
Plainfield, IL 60586
815-782-2299
www.catonfielddental.com

Authorization for Treatment of Minor Child

By completing this form. I authorize an alternate decision maker to consent to, and be involved in, dental treatment services and care of my Minor Child at Catonfield Dental.

Minor Child's Name: _____ (Last) _____ (First) _____ (Age) _____ (DOB)

IF your child is coming alone, complete below:
Initials

_____ I authorize the providers at Catonfield Dental to provide the Minor Child with the following treatment in my absence (Please **circle** the treatment you authorize):

- X-rays
- Teeth cleaning
- Sealants
- Fillings
- Extraction of "baby" teeth
- Extraction of "adult" teeth
- Root canal treatment
- Other: _____

IF your child is accompanied by an adult sibling, guardian, step-parent, or grandparent:
Initials

_____ Designation and identification of the Parent/Guardian Substitute. I appoint the following individual(s) to obtain access to Protected Health information, give informed consent for dental treatment, or otherwise authorize care/treatment for the Minor Child.

_____ (Name of Parent/Guardian Substitute) _____ (Mailing Address) _____ (Phone #)

Please complete below:
This consent is valid for one (1) year beginning on _____, 20 _____.This authorization may be revoked by me at any time prior to that expiration date by providing the office with written notice.

To ensure that the Parent/Guardian Substitute has access to Protected Health Information needed to make informed consent decisions, I authorize Catonfield Dental to provide the above named Parent/Guardian Substitute with Protected Health information relating to the Minor Child only. "Protected Health Information" means all dental records relating to the Minor Child, which are protected and confidential as is defined by HIPAA/HITECH, and include: account information, appointments, and treatments planned or given. I also agree to release Catonfield Dental and the providers from liability for any claims resulting from release of Protected Health Information in reliance upon this authorization.

I have carefully read and considered this consent for before signing it.

_____ (Signature of Parent or Guardian) _____ (Relationship to Minor Child) _____ (Date)

_____ (Name of Parent or Guardian) _____ (Mailing Address) _____ (Phone #)

_____ (Signature of Witness) _____ (Date)