

Dr. Deborah A. Ashcraft
460 W. Martintown Rd.
North Augusta, S.C. 29841

To Whom It May Concern:

I, _____ give permission for _____
to transport my child/children to Dr. Ashcraft's office for their appointments. I also authorize
them to sign the treatment plan in my absence and to schedule appointments as needed. In order to
prevent any delays in my child's/children's treatment and to remain in compliance with the new Health
Privacy Act, I authorize Dr. Ashcraft and her office staff to discuss treatment/appointments/fees with
the above named individual(s) either directly (in person) or indirectly (phone contact).

I understand in signing this agreement that it will remain in force until such time that I may
choose, in writing, to revoke it.

This agreement applies to the following child/children:

_____	_____
_____	_____
_____	_____
_____	_____

Designated Contact: _____

Date: _____

Parent's Signature: _____

Date: _____

Witness: _____

Date: _____