Deborah A. Ashcraft, DMD, PC

PEDIATRIC & ADOLESCENT DENTISTRY

To Whom It May Concern:

I, _____ give permission for _____ to transport my minor child/children to Dr. Ashcraft's office for their appointments. I also authorize for 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 (HIPAA), 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). This includes permission to administer treatment aids such as; nitrous oxide (laughing gas) or valium (sedative) to my child/children.

I understand by 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: _____

460 W. Martintown Rd., North Augusta, SC 29841 / 803-279-9901