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 dental 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 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:

_____ _____

_____ _____

_____ _____

_____ _____

Parent's Signature: _____ Date: _____

Witness: _____ Date: _____

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