Smiling with Love
Pediatric Dentistry

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NOTARIZED PERMISSION LETTER

I, _____, am the Parent/Legal Guardian of the child/children listed below:

Patient's Name: _____ DOB: _____

_____ DOB: _____

_____ DOB: _____

_____ DOB: _____

I hereby give legal consent for the following person/people to be the responsible party for the above-named patient(s):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

This document allows the above person/people to authorize medical/dental treatment and make decisions for me in my absence. I understand that, at any time, I have the right disallow any or all persons to make decisions for me. This authorization is valid for one year and must be renewed one year from the date signed below.

Signed,

X_____ X_____

SIGNATURE Parent/Legal Guardian Name PRINTED Parent/Legal Guardian Name

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Below to be filled out by the NOTARY WITNESS

This is signed before me on this _____ day of _____(month), _____ (year).

X_____

Notary Witness Signature