ACKNOWLEDGEMENT & CONSENT BY PARENT/GUARDIAN TO TRANSFER AUTHORITY FOR TREATMENT

I, ______________________________ certify that I am the parent/legal guardian of the following child: ______________________________ (the patient).

I hereby give permission to, request and authorize the following person(s):

____

to transport the patient to and from Kids to College Pediatric Dentistry for his/her scheduled appointment, and to make any additional decisions as needed regarding consent for the patient's treatment. I designate the formerly named person(s) to stand in for me as the parent/guardian of the patient at my request, including involvement in the patient's care and knowledge of the patient's health information and records.

I have already been advised of the planned treatment for the patient, and have received sufficient consent information explaining the diagnosis, procedures, risks, benefits, alternatives and prognosis. I hereby authorize Kids to College Pediatric Dentistry to examine and treat the patient, including treatment of conditions which arise during the appointment.

I am aware of my liability for costs of the patient's care consented to by the person(s) but not covered by my Insurance. I know that it is in the patient's best interest for the parent to be present; however, I have opted to delegate my decision-making authority to the person(s) listed above.

This form is valid for one year from the signature date.

______________________________ ______________________________

Signature of Parent or Guardian Date

____

Kids to College Pediatric Dentistry Witness

31955 Castle Court, suite 2 North
Evergreen, Colorado 80439
303.674.0779

10146 W. San Juan Way, Suite 220
Littleton, Colorado 80127
303.979.9500