AUTHORITY TO CONSENT BY PERSON OTHER THAN PARENT OR LEGALLY AUTHORIZED REPRESENTATIVE

Patient Name

First Name _____ Last Name _____

Date of Birth

Month Day Year

Age _____

Iris Pediatric Dentistry requires a parent or legally authorized representative to be present at the initial patient appointment for a minor child (i.e., someone who has not had his/her 18th Birthday). While it is important for the parent or legally authorized representative of a minor child to be present for all visits, we realize that this is not always possible. This Form may be used to allow an adult, other than a parent or legally authorized representative, to serve as a substitute decision maker ("Substitute") for non-emergent dental care at Iris Pediatric Dentistry as allowed by Colorado Revised Statute (C.R.S.) 15-14-105.
If you would like to appoint a Substitute, please review and complete this Form and sign below.
This Form will remain in effect for the dates specified below, unless you revoke it in writing.

Authorization: As the Parent or Legally Authorized Representative of _____ **(the "Minor"). Date of Birth:** _____

I request that authority to consent be granted to: Full name of substitute legal guardian ("the Substitute ")

First Name _____ Last Name _____

"The Substitute's" Address: (Street Address, City, State, Zip Code)

"The Substitute's" Phone Number _____

Whose relationship to the Minor is: Substitute's relationship to the patient

_____

*** Note: Authority to consent may not be granted to an individual other than a parent or legally authorized representative for major healthcare decisions as determined by the Minor's healthcare provider.**

Approving all non-emergent, non-major care rendered at Iris Pediatric Dentistry

Yes
No

Approving just for the following care, condition(s), procedure(s), and/or treatment(s) (e.g., dental cleaning and examination, etc.)

Yes
No

Please list the approved care, condition(s), procedure(s), and/or treatment(s) here (if No, please enter N/A):

_____
_____
_____
_____

I would like to be contacted in the event a medical or dental decision needs to be made for additional, unanticipated medical services beyond the reason for the patient's visit.

Yes
No

Limitations (if none, please enter N/A)

_____
_____
_____
_____

Please identify any limitations on the kinds of medical services for which this authorization is given, or any limitations on the time frame for which this authorization is given. If none, please state "none."

This form is effective from this start date

Month Day Year

To this end date (if no end date selected, this form will be valid for 1 year from effective date)

Month Day

By signing below, I confirm that the Substitute to whom I have given consenting authority has the ability to obtain, process, read, and understand health information so that an appropriate and informed health care decision can be made. I understand that if the treating dental providers have any doubts as to the capability of the Substitute to provide permission for medical care, they may defer non-urgent/non-emergent care until appropriate permission may be obtained. By completing this Form, I consent to the sharing of the Minor's protected health information with the Substitute. I agree to accept financial responsibility for all care and services delivered pursuant to this Form.

Legally Authorized Representative: Please print.

First Name

Last Name

Legally Authorized Representative's contact phone number: Please enter best contact number for legally authorized representative

Signature

Date