# DRS. KEARNS, ASHBY, RAJCHEL & ASSOCIATES

*DENTISTRY FOR INFANTS, CHILDREN & TEENS*

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## POWER OF CONSENT FORM

(Step parents also need authorization)

I, ________________________________________, the parent or legal guardian of
(Name of Parent or Legal Guardian)

________________________________________________________________, authorize the individuals below
(Name of Child(ren))

to accompany my child(ren) to visits and consent to necessary dental exams and/or treatment and disclosure of dental information regarding the initial and/or follow-up care of my child(ren) during the visits.

______________________________________ ______________________________
(Name of person bringing child *other* than a parent) (Relationship to child)

______________________________________ ______________________________
(Name of person bringing child *other* than a parent) (Relationship to child)

______________________________________ ______________________________
(Name of person bringing child *other* than a parent) (Relationship to child)

The person named above may consent to the examinations and treatment for my child with Drs. Kearns, Ashby, Rajchel & Associates.

This authorization/consent is effective on this,

____________ day of __________________________, 20__, in. This document is effective until revoked by me in writing to Drs. Kearns, Ashby, Rajchel & Associates.

____________________________________ ____________________________________
(Signature of Parent/Legal Guardian) (Printed Name of Parent/Legal Guardian)