Woodside Pediatric
• Dentistry •

Dr. Jennifer Woodside
331 Walker Drive, Suite 2
Warrenton, Virginia 20186
(540) 341-0014, (540) 341-0303 fax

Consent for Treatment/HIPPA Information Release without Parent/Guardian

I, _____(parent/guardian), give Woodside Pediatric Dentistry consent to treat the **following children** with the authorized individuals while I am not present: **NAME OF CHILDREN:**

_____

_____

I also give the authorized individuals permission to make decisions regarding my child's dental treatment, medical treatment, and behavior management. _____(initials)

I authorize Woodside Pediatric Dentistry to discuss medical, dental, and insurance information with the authorized individuals. _____(initials)

I understand out-of-pocket expenses are due at the time of treatment. _____(initials)

I authorize the following individuals to bring the **above children** to their dental appointments, make the above decisions, and have knowledge of HIPPA sensitive information.

Name:	Relationship:
Name:	Relationship:
Name:	Relationship:

_____ (initials) **NO ONE OTHER THAN PARENTS WILL BRING CHILD**

Parent/Guardian Name (printed)_____
Parent/Guardian Name (signature)_____Date_____

Parent/Guardian Cell Phone _____