



# Frederick Pediatric Dentistry, LLC

77 Thomas Johnson Drive, Suite A  
Frederick, MD 21702

## 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  
(Name of Child/Children)

below to accompany my child/children 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/children during the visits.

\_\_\_\_\_  
(Name of person Bringing child other than parent)

\_\_\_\_\_  
(Relationship to child)

\_\_\_\_\_  
(Name of person Bringing child other than parent)

\_\_\_\_\_  
(Relationship to child)

\_\_\_\_\_  
(Name of person Bringing child other than parent)

\_\_\_\_\_  
(Relationship to child)

The person(s) named above may consent to the examinations and treatment for my child.

This authorization/consent is effective on this, \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

This Document is effective until revoked by me in writing to Frederick Pediatric Dentistry, LLC.

\_\_\_\_\_  
(Signature of Parent/Legal Guardian)

\_\_\_\_\_  
(Printed Name of Parent/Legal Guardian)

