

PARENTAL CONSENT FOR TREATMENT

PATIENT'S NAME: _____

MRN: _____

I, _____, the undersigned,
(name of parent)

hereby authorize my child, _____,
to seek dental care at South Cove Community Health Center
in my absence.

I can be reached at _____
(phone #)

if you have any questions.

(printed name of parent)

(signature of parent)

Date: _____