UB DENTAL

AUTHORIZATION FOR NON-PARENT/GUARDIAN TO CONSENT FOR MINOR'S CARE

I/We, _____, [Insert Parent[s]/Legal Guardian[s] Names] parent(s)/legal guardian(s) of the minor child, _____, [Insert Minor Child's Name and Date of Birth] authorize _____ "Caregiver" [Insert Name of Adult Caregiver who is Non-Parent/Non-Legal Guardian] to consent and make dental and health care decisions for my minor child, including but not limited to:

- To consent and accompany the minor child in dental, medical or health care procedures and administration of medication as legally prescribed by the dentist or health care provider.

- To be given full access to the minor child's dental and health records (both verbally and written records), including information about diagnosis, treatment and options, which the dentist or health care provider would have given to me directly as the minor child's parent/legal guardian.

- To give written and verbal consent for dental procedures, including those with financial liability. I understand that I am and remain solely responsible and liable for any copays, charges, costs or fees to which Caregiver consents.

This Authorization ends on _____, 202__, or until I provide the UB School of Dental Medicine with written notice ending it and is governed by the laws of the State of New York. I understand that, despite this Authorization, the UB School of Dental Medicine, its employees and staff, in its/their sole discretion, may decide not to treat minor child, and instead require my presence during my minor child's treatment or care.

BY SIGNING BELOW, YOU ACKNOWLEDGE THAT YOU HAVE READ AND UNDERSTAND THE TERMS AND CONDITIONS AND CONSENT TO ENABLE TREATMENT DECISIONS MADE BY THE CAREGIVER NAMED ABOVE.

IF YOU HAVE ANY QUESTIONS ABOUT THIS FORM, PLEASE CONTACT THE WELCOME CENTER AT 716-262-9750.

[*Parent or Guardian*]

Sworn to before me this
___ day of _____, 202__

_____
Notary Public

OR

_____
[Witnessed by *School of Dental Medicine Employee*]