Sachin S. Parulkar, D.D.S., L.L.C.
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Authorization to Seek Medical/Dental Care

Patient(s) Name(s): ____

____

I authorize Delaware Pediatric Dentistry – Sachin S. Parulkar, D.D.S., L.L.C. and personnel to treat my child ________________ in my absence when the child is brought into the office by my designee(s).

The following person(s) named below are authorized to schedule appointments and seek dental care and treatment for the above names patient(s) with the doctors and staff of Delaware Pediatric Dentistry. Please be advised the individuals named below are people who will have access and knowledge of private health information:

Name: ______________________________ Relationship: _______________________

Name: ______________________________ Relationship: _______________________

Name: ______________________________ Relationship: _______________________

Name: ______________________________ Relationship: _______________________

Name: ______________________________ Relationship: _______________________

I, ______________________, parent/legal guardian of the above named patient(s) give permission for the above named authorized individual(s) to seek medical/dental care in my absence.

____
Parent/Legal guardian Printed Name

____
Parent/Legal guardian Signed Name

____
Date