



Jake Fried DDS

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Child Care Authorization

I, _____, the parent/guardian of the below named minor(s), grant temporary authority to _____, limited to the below defined powers, over the following children:

The power granted are limited to the following (Please Initial):

- ___To discuss with the doctor and office staff protected health information
- ___To schedule routine hygiene appointments and operative appointments with nitrous oxide
- ___To discuss operative treatment and review nitrous oxide when indicated
- ___To sign informed consent forms for treatment
- ___To supervise routine hygiene appointments and operative appointments with nitrous oxide
- ___To authorize diagnostic x-rays when indicated
- ___To authorize fluoride treatment when indicated
- ___To review post-operative instructions and care for the child post operatively

Parent/legal guardian must be available by phone at the time of treatment. If parent/legal guardian is not available by phone, the doctor may complete partial or no treatment or will act in the best interest of the child.

Best available Phone # (_____) _____

This grant of authority is effective as of _____ and shall remain in effect until terminated by the undersigned parent/guardian.

This grant of authority is signed this _____ day of _____ in the County of _____, in the state of New York.

Signed,

_____ (Parent/guardian)