Alternate Supervision

Patient Name: ____

This form authorizes ***someone other than the legal parent/guardian*** to bring my child for dental treatment by Kai D. Hart, DMD or Hart Dental Care. Any designated individual must be 18 years of age or older, and have a photo I.D. This letter allows us to provide medically necessary treatment to my child when brought by an individual designated below. This form also acts as a waiver of your child's HIPAA rights, as disclosure of potential health information, treatment and future visits may be presented to the attending adult. Your failure to provide the following information or authorization will prevent us from treating your child outside of your presence.

Name of Person	Relationship	Phone
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________

____________________________________ ____________________________

Signature of Parent/Guardian Date