LVDHC
Lac Vieux Desert Health Center

# Minor Consent Authorization for Treatment Decisions and Consent

I, _____ **(Parent/Legal Guardian Name)**, am the parent/legal guardian of _____ **(Minor's Name)**.

I hereby authorize _____ **(Authorized Person's Name)** to accompany the above-named minor to dental appointments, make decisions regarding examination and treatment, and sign any necessary consent forms related to the minor's dental care in my absence.

***This authorization is in effect for TODAY ONLY. Each time the minor patient is seen a new consent must be signed for that date by guardian/parent.***

**Parent/Legal Guardian Signature:** _____

**Date:** _____

**Phone Number:** _____

**Authorized Person Signature:** _____

**Relationship to Minor:** _____

*This consent form is intended for use with minor patients and should be kept in the patient's dental record.*

**PO Box 9, N5241 US Hwy 45**
**Watersmeet, MI 49969**
**Phone: 906-358-4588 Fax: 906-358-4118**