POWER OF ATTORNEY
FOR CONSENT TO AND AUTHORIZATION OF
DENTAL CARE AND TREATMENT

The undersigned, _____,
(name(s) of parent(s) or guardian(s))

residing at _____,
(address)

is/are the parent(s) or legal guardian(s) of _____ ("child").
(name of child)

I/We hereby, make, constitute and appoint _____,
(name of attorney-in-fact)

as the true and lawful attorney-in-fact of the undersigned, to act in the name, place and stead of the undersigned to (i) make decisions relating to my/our child's dental care, (ii) consent to and authorize the performance of my/our child's dental examination and treatment, and (iii) execute any documents and take any actions necessary to give effect to the foregoing.

As set forth above, the power conferred by the undersigned is specifically limited to decision-making regarding my/our child's dental care and the ability to consent to and authorize the performance of my/our child's dental treatment.

The person appointed as attorney-in-fact herein may have access to any and all records, including, but not limited to, insurance records relating to my/our child's dental care. Accordingly, the person appointed as attorney-in-fact herein is also hereby designated as a "Personal Representative" as defined by 45 CFR 164.502(g), commonly known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and shall have the same access to my/our child's dental care and treatment information as I/we would have if present.

I/We confer this power to consent freely and knowingly in order to provide for my/our child, and not as a result of pressure, threats or payments by any person or agency. There are no court orders now in effect that would prohibit any of the undersigned from conferring the powers conferred to the attorney-in-fact herein upon another person.

This document shall remain in effect until it is revoked by any of the undersigned by notifying, in writing, our Robbinsville Pediatric Dentistry and the person designated herein as attorney-in-fact.

IN WITNESS WHEREOF, I/we have executed this Power of Attorney on this ____ day of _____, 20___.

WITNESS: Parent(s)/Guardian(s):

_____ (sign)

(print) _____

_____ (sign)

(print) _____

Check the appropriate box below if only one parent or guardian is executing this Power of Attorney:

[ ] The non-signing parent/guardian's consent to this power of attorney has been obtained.
[ ] The consent of the non-signing parent/guardian is not necessary or is inapplicable.

Attorney-in-Fact Information:

Relationship to Patient, if any: _____

Phone number: