TEBO DENTISTRY FOR KIDS LILBURN
609 BEAVER RUIN ROAD NW
SUITE A
LILBURN, GEORGIA 30047
PHONE: 770-925-3300

TEBO FAMILY DENTISTRY LILBURN
609 BEAVER RUIN ROAD NW
SUITE B
LILBURN, GEORGIA 30047
PHONE: 770-925-3300

TEBO DENTISTRY FOR KIDS GAINESVILLE
3535 THOMPSON BRIDGE ROAD
GAINESVILLE, GEORGIA 30506
PHONE: 770-925-3300

TEBO DENTISTRY FOR KIDS DACULA
1152 AUBURN ROAD
SUITE 101
DACULA, GEORGIA 30019
PHONE: 770-925-3300

Authorization for Caregiver to Act for Parent or Guardian

Child's name: ___________________________________ Date of birth: ___________________________

Child's name: ___________________________________ Date of birth: ___________________________

Child's name: ___________________________________ Date of birth: ___________________________

Child's name: ___________________________________ Date of birth: ___________________________

Caregiver's name: _______________________________________ Phone: ___________________________

Relationship of caregiver to children: ____

I, the undersigned parent or guardian of the children named above (or child, if just one), entrust the care of the children to the caregiver named above during any present or future visit to any office of Tebo Dental Group. The purpose of this Authorization is to permit the children to receive dental treatment when I cannot be present in person. I understand that only adults (18 or older) may act as caregivers under this Authorization.

The caregiver has the power and authority, on my behalf:

- to receive and disclose all health information, and to make all decisions, related to the dental treatment of the children at any office of Tebo Dental Group;
- to execute in my name any consent to treatment and any other consent or document relating to the exercise of the powers and authorities granted in this Authorization;
- to commit me to pay all charges for dental treatment to which the caregiver consents; and
- to perform any other act necessary or appropriate to the exercise of powers and authorities granted by this Authorization as fully as I could do if present in person.

Every act the caregiver lawfully does pursuant to this Authorization shall be binding on me. I understand that I will be liable for all charges for dental treatment to which the caregiver consents pursuant to this Authorization.

This Authorization shall remain in effect until completion of dental treatment of the child(en) at any office of Tebo Dental Group or until I revoke this Authorization as provided below.

I understand that I have the following rights: I can revoke this Authorization at any time by giving my oral or written revocation to the office of Tebo Dental Group at which my children are being treated. My revocation will not be effective for any disclosures already made or any actions already taken in reliance on this Authorization. Tebo Dental Group may not condition treatment, enrollment in any health plan or eligibility for any benefits on whether or not I sign this Authorization. I am authorizing disclosure of information protected under federal law. This information, once disclosed, may be subject to re-disclosure by the recipient and may no longer be protected by federal law. I have received a copy of this Authorization.

I HAVE READ AND I UNDERSTAND THIS AUTHORIZATION.

x____ Date signed: ________________________

Signature of parent or guardian

Printed name: ___________________________________ Phone: ___________________________

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