From the office of Dr. Deborah A. Himelhoch, D.D.S., M.S., M.M.sc.

Patients name (s): ____

I, ________________________, give __________________________________permission to
(Parent/guardian) (Person accompanying child)

verify health history and make decisions regarding my child's treatment at Dr. Deborah Himelhoch's office.

X____

(PARENT or GUARDIAN Signature and Date)