Kinderzauberzähne
Gemeinschaftspraxis für Kinder- & Jugend-
zahnheilkunde und Kieferorthopädie

Power of attorney for the visit to the dentist

Authorizer: _____ (First and last name), born on _____
(Parent and guardian)

Authorized person: _____ (First and last name), born on _____

I hereby authorize the above-named authorized person to accompany my

child _____ (First and last name), _____ (born on) to the

pediatric dentist and the following powers

- make decisions regarding necessary examinations, e.g., including taking x-rays
- make decisions related to dental therapy and treatment, e.g. injections, type of therapy, additional cost agreements/co-pay
- other decisions _____

The power of attorney is valid from _____ to _____.

The power of attorney is only valid for the dental visit on _____.

It can be revoked by me at any time and is only valid if the authorized person can identify himself/herself by means of an official identification document.

Release from the obligation to maintain dental confidentiality
I (authorizer see above) hereby release the Joint Practice for Pediatric & Adolescent Dentistry and Orthodontics from the duty of confidentiality vis-à-vis the above-named authorized person. I agree that all necessary information in connection with the dental treatment of my child may be given to this person.
I am aware that I voluntarily submit the declaration of release from confidentiality and that I may revoke this declaration at any time with effect for the future.

_____ _____
City, Date Authorizer (Parent and guardian)

Dr. Miriam Landgraf, Zahnärztin | **Dr. Margita A. Beck,** Zahnärztin | **Dr. Luise Sauer,** Kieferorthopädin
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