Alternative Chaperone Consent Form

Date:_________________________

In my absence, I hereby give authorization for the person(s) listed below to bring my child(ren) to Greater Washington Dentistry, the offices of Shohreh Sharif, D.D.S. & Associates and to consent for any and all recommended dental services. Legal guardian must bring child to first dental appointment.

Child(ren) names and date of birth:	Authorized person(s)/Relationship to child(ren)
______________________________________	____
______________________________________	____
______________________________________	____
______________________________________	____

Parent/Legal Guardian signature:____

Printed name:____

This authorization will remain in effect until changes are made by the parent/guardian as signed above.

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Minor Children (ages 15, 16, and 17 only)

My child(ren), _______________________________________may be seen for dental attention at Greater Washington Dentistry, the offices of Shohreh Sharif, D.D.S. & Associates WITHOUT a parent or legal guardian present.

Parent/Legal Guardian:____

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Adults (ages 18 years or older-ONLY)

I give my consent for the listed person(s) below to have any and all access to my dental records on file with Greater Washington Dentistry, the offices of Shohreh Sharif, D.D.S & Associates.

Authorized person(s)/Relationship: ____

Adult Signature:____