BRINK & WHITE
PEDIATRIC DENTAL ASSOCIATES

LIMITED POWER OF ATTORNEY FOR DENTAL HEALTH CARE

BRINK AND WHITE PEDIATRIC DENTAL ASSOCIATES

I/We, _____ (parent/legal guardian) and _____ (parent/legal guardian) of

_____(child's name) born on _____
_____(child's name) born on _____
_____(child's name) born on _____

appoint _____ (name) as my attorney-in-fact and agent (my "Agent") to make to dental care decisions for my child(ren).

1. **Effective Date and Durability**: This limited power of attorney shall be in effect immediately and remains in effect until I revoke it.
2. **Agent's Powers:** I grant to my/our agent full authority to make dental health care decisions for my child(ren). I also grant to my/our agent full authority to request copies of and receive medical records for my child(ren).
3. **Protection of Third Parties Who Rely On My Agent:** No person who relies in good faith upon any representation by my Agent shall be liable to me/us, my/our estate, my/our heirs or my/our assigns for relying upon the Agent's authority.
4. **Administrative Provisions:** This special power of attorney is intended to be valid in any jurisdiction in which it is presented.
5. **Revocation:** I understand that after executing this special power of attorney, I may revoke the authority granted to my/our Agent by notifying my Agent orally or in writing; or I may revoke the authority granted to my/our Agent to make dental health care decisions by notifying Brink and White Dental Associates orally or in writing.
6.

I/we sign my/our name(s) to this Special Power of Attorney for Dental Health Care on this ____ day of _____(month), 20_____.

_____ (Parent/Legal Guardian)

_____ (Parent/Legal Guardian)

We, the subscribing witnesses hereto, declare under penalty of perjury under the laws of Tennessee that the person who signed this document is personally known to each one of us to be the principals; that the principals signed this durable power of attorney in our presence; that the principals appear to be of sound mind and under no duress, fraud or undue influence; that neither one of us is the person appointed as attorney-in-fact by this document; that neither one of us is a health care provider, an employee of a health care provider, the operator of a health care institution or an

employee of an operator of a health care institution; that neither one of us is related to the principal by blood, marriage, or adoption; that, to the best of our knowledge, neither one of us does, at the present time, have a claim against any portion of the estate of the principal upon his or her death; and, that, to the best of our knowledge, neither one of us is entitled to any part of the estate of the principal upon the death of the principal under a will or codicil thereto now existing, or by operation of law.

_____	_____
_____ (printed name)	_____ (printed name)
Witness	Witness
_____	_____
_____	_____
Address	Address

STATE OF TENNESSEE
COUNTY OF _____

On this ___ day of _____, 20___, before me, the undersigned authority, appeared _____ (parents/ legal guardians), _____ and _____ _____ (witnesses), personally known to me (or proved to me on the basis of satisfactory evidence) to be the persons whose names are subscribed herein and acknowledge to me that they executed the same in their authorized capacities, and that by their respective signature executed this instrument for the purposes above stated and set forth.

WITNESS my hand and official seal the date aforesaid.

_____
NOTARY PUBLIC

My Commission Expires: _____

**** This power of attorney shall be acknowledge and executed in the presence of a Notary Public by the principal (parent/legal guardian) and in the presence of at least two witnesses. The health care provider nor any of the health care provider's employees shall serve as a witness.***