DENTAL RELEASE SPECIAL AUTHORIZATION FORM

I authorize the following name person/persons to authorize treatment for my child/children by this facility.

I understand that I am responsible for services rendered for treatment and payments authorized by my personal representatives.

I understand that I may terminate this authorization form. I must notify this office in writing regarding termination and effective date.

NAME OF REPRESENTATIVE	RELATIONSHIP
______________________________	____________________
______________________________	____________________
______________________________	____________________

NAME OF CHILDREN	AGE
______________________________	___________
______________________________	___________
______________________________	___________
______________________________	___________
______________________________	___________

Printed Name: ________________________________

Signature: ________________________________

Relationship to Child: ________________________________

Today's Date: ________________________________

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