Healthy Smiles
Children's Dentistry
Creating Smiles with Star Power

Medical Release Special Authorization Form for Minors

I,_____, authorize the following named person/ persons to authorize Dr. Mila Davis and Staff at Healthy Smiles Children's Dentistry to treat my child/ children at this facility.

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

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

All minors under the age of 18 must be accompanied by an adult or legal guardian for the duration of appointment.

Name of Personal Representative **Relationship**

_____

_____

_____

Name of Children **Ages**

_____

_____

_____

_____

_____

Signed by Parent or Legal Guardian:_____

Date:_____