MEDICAL RELEASE SPECIAL AUTHORIZATION FORM FOR MINORS

I, _____,(Parent/Legal Guardian) authorize the following name person/persons to authorize (Medical/Dental) 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 facility in writing regarding termination and effective date.

NAME OF PERSONAL REPRESENTATIVE	RELATIONSHIP	DOB	Phone#
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

NAME OF CHILDREN	AGES
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Signed by: _____ _____

Relationship to Child: _____ CHDC Authorized Witness Date

Date: _____