Authorization for Treatment of a Minor

I am the parent or guardian of _____ who is a minor child, and I do hereby authorize and consent to any x-ray, examination, anesthetic, or dental treatment rendered under the general, direct, or indirect supervision of Dr. Halpern and his associates, staff members, or agents, as he/she may deem necessary. I understand that in case of an emergency appropriate action will be taken by Dr. Halpern and his associates, staff members, or agents.

This authorization will remain in effect until cancelled in writing by me.

Signature_____ Date_____

ParentName_____

Address_____

Phone No: Home_____

Work_____

Cell_____