Crofton Dental Suites
2191 Defense Highway, Suite 210
Crofton MD 21114
(410)721-2610 email: croftondentalsuite@gmail.com

MEDICAL RELEASE AUTHORIZATION FOR MINORS

I, ____ , (parent or legal guardian), authorize the person/persons listed below to authorize (Medical/Dental) treatment for my child/children at Crofton Dental Suites.

I understand that I am responsible for services rendered for treatment and payments authorized by my personal representative(s).

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

NAME OF PERSONAL REPRESENTATIVE	RELATIONSHIP
______________________	______________________
______________________	______________________
______________________	______________________

NAME OF CHILDREN	AGE
______________________	____________
______________________	____________
______________________	____________
______________________	____________
______________________	____________

This will remain in effect until I rescind it in writing.

Signed by: ______________________________

Relationship to Child: ______________________________

Date: ______________________________