LARSON ORTHODONTICS

Dr. Douglas M. Larson
Dr. James M. Larson
680 Fairmount Ave., W.E.
Jamestown, NY 14701
(716) 483-1718

AUTHORIZATION FOR A THIRD PARTY TO CONSENT TO TREATMENT OF A MINOR

I am the ____ Parent
____ Guardian
____ Other person with legal custody _____
(describe legal relationship)

of *(name of minor)* _____, a minor.

I hereby authorize *(name)* _____, to act as my agent to consent to any examination, x-ray, diagnosis and treatment which is recommended by, and to be rendered under the general or special supervision of Dr. Douglas Larson, Dr. James Larson and staff at Larson Orthodontics, 680 Fairmount Ave. W.E., Jamestown, NY 14701.

I understand that this authorization is given in advance of any specific diagnosis, treatment, or care being required, but is given to provide authority to the above-named agent to give consent to any and all such diagnosis, treatment or care that Dr. Larson recommends.

I further understand that I am responsible for any and all fees incurred during the course of treatment.

This authorization shall remain in effect until revoked in writing.

Date: _____

Signature: _____
***circle relationship**: parent / legal guardian / person having legal custody*