LEFCOE, WEINSTEIN, SACHS & SCHIFF
FAMILY DENTISTRY, ORTHODONTICS
&
DENTISTRY FOR CHILDREN

# AUTHORIZATION

I authorize the following person(s) to bring my child, _____, in for appointments and approve doctor recommended treatment. I also give this practice my permission to release the doctor's recommended future treatment to said authorized person(s):

| Name | Relationship | Phone Number |
|---|---|---|
| Name | Relationship | Phone Number |
| Name | Relationship | Phone Number |
| Name | Relationship | Phone Number |

Signature Date