MINOR TREATMENT RELEASE FORM

I, ____ certify that I am the parent or legal guardian of the minor
___________________________________, and as such, I hereby give authority to the below designated adults
(must be at least 18 years of age) for the sole purpose of obtaining or arranging any dental care for the minor
as may be deemed necessary for the well-being of the minor when not accompanied by a parent/legal
guardian or should either parent/legal guardian be unreachable by telephone.

THEREFORE, I hereby approve and empower the below listed individuals with the authority to arrange and/or
consent for any and all dental care and treatment of the minor in my absence.

____ __________________________________
(Signature of Parent/Legal Guardian) (Date)

____ __________________________________
(Name of Parent/Legal Guardian) (Relationship to)

____ __________________________________
(Home/Work Number) (Cell Number)

AUTHORIZED INDIVIDUALS

____
(Name) (Relationship to)

____
(Name) (Relationship to)

____
(Name) (Relationship to)

196 S McCleary Rd
Excelsior Springs, MO 64024
816-630-5713