MEDICAL TREATMENT AUTHORIZATION AND CONSENT FORM

The following form is designed for those situations where minors are unaccompanied by either biological parent(s) or legal guardians. This "Medical Treatment Authorization and Consent Form" gives authority to a designated adult to arrange for medical/dental care of a minor. This is extremely important, in that, medical/dental care cannot be provided to a minor without approval by the biological parent(s) or legal guardians, unless there is written consent authorizing an agent to give approval.

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Name of Minor Child **Date of Birth**

The Undersigned do hereby authorize Renée L. I. Owen, DDS, PC as agent for the Undersigned to consent to any X-Ray, anesthetic, medical, dental, or surgical diagnosis or treatment and hospital care for the above named minor which is deemed advisable by and to be rendered under the general or special supervision of any physician and/or surgeon, licensed under the Provision of Medicine Practice Act or of any dentist licensed under the Dental Practice Act, whether such diagnosis or treatment is rendered at the office of said physician or dentist, at a hospital, or elsewhere.

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Name of Designated Adult **Relationship**

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Name of Designated Adult **Relationship**

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Name of Designated Adult **Relationship**

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Printed Name of Biological Parent or Legal Guardian

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Biological Parent or Legal Guardian Signature **Date**

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Signature of Witness