

TREATMENT AUTHORIZATION

We, the undersigned, parents of _____, minor, do hereby consent to any x-ray examination: local anesthetic, dental, or surgical diagnosis and treatment; that may be rendered to said minor under the general, specific, or special instructions of **DANIEL V. LAUNSPACH, D.D.S.**

We give _____ permission to bring this child for treatment for these procedures and be responsible for any decisions necessary to complete treatment when parent or legal guardian is not available.

It is understood that this consent is given in advance of any specific diagnosis or treatment being required, but it is given to encourage those persons who have temporary custody of my child or children, as well as said dentists, to exercise their best judgment as to the requirements of such diagnosis or dental/surgical treatment. If a phone number is left, the office will attempt to contact me regarding changes in diagnosis or treatment.

This consent shall remain effective unless revoked in writing and delivered to said dentist or person entrusted with the custody, care, or control of said minor child or children.

Dated: _____

Father

Mother

Legal Guardian

Witness: _____