R.O.A.D.S.
COMMUNITY CARE CLINIC

Special Authorization Form for Minors

I, _____, authorize the following named person/persons to
(Name of Parent/Legal Guardian)
authorize treatment (medical/dental) for my child/children by the ROADS Community Care Clinic.

- I understand that I am responsible for services rendered for the treatment and payments authorized by my personal representatives.
- I understand that I may terminate this authorization form. If I choose to do so, I must notify the clinic in writing regarding termination and effective date.

Please list who we may discuss your treatment information with and who may bring your child to his/her dental appointments.

Anyone listed below must show their ID so we can verify their identity.

Name of personal representative	Relationship	DOB	Phone number
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Name(s) of child/children	Ages
_____	_____
_____	_____
_____	_____

_____ _____
Parent/Legal Guardian (Print Name) Relationship

_____ _____
Parent/Legal Guardian (Signature) Date

_____ _____
Witness's Signature Date