Wells Family Dentistry

AUTHORIZATION TO CONSENT TO HEALTH CARE FOR MINOR

I, __________________________ am the custodial parent having legal custody of ____, a minor child, age______________, born _________________________. I authorize L. Brett Wells, D.D.S, P.A. to do any acts which may be necessary or proper to provide for the health care of the minor child, including, but not limited to, the power (**i**) to provide for such health care at any hospital or other institution, or the employing of any physician, dentist, nurse, or other person whose services may be needed for such health care, and (**ii**) to consent to and authorize any health care, including administration of anesthesia, X-ray examination, performance of operations, and other procedures by physicians, dentists, and other medical personnel, except the withholding or withdrawal of life-sustaining procedures.

This consent shall be effective from the date it is executed until the date I terminate it in writing. By signing here, I indicate that (**i**) I have the understanding and capacity to recognize the importance of, to communicate, and to assign the health care decisions covered by this document, (**ii**) I am fully informed as to the contents of the document, and (**iii**) I understand the full scope and importance of this grant of powers to the agent named herein.

_________________________ _________________________

(Custodial Parent's Signature) (Date)