**MEDICAL RELEASE**
**SPECIAL AUTHORIZATION FORM**

I, _____, authorize the following name person/person(s) to authorize (Medical/Dental) treatment for my child/children by Erika E. Gabor, DMD. I allow Dr. Gabor and staff to share health information with the following person(s).

I understand that I am responsible for services rendered for treatment and payments authorized by my personal representatives.

I understand that I may terminate this authorization form. I must notify Erika E. Gabor, DMD in writing regarding termination and effective date.

| NAME OF PERSONAL REPRESENTATIVE | RELATIONSHIP |
|---|---|
| | |
| | |
| | |

| NAME OF CHILDREN | AGES |
|---|---|
| | |
| | |
| | |
| | |
| | |

Signed by: _____

Relationship to child: _____

Date: _____