TIFFANY M. BECKER, M.D.
827 DEEP VALLEY DR., SUITE 201
ROLLING HILLS ESTATES, CA 90274

MEDICAL RELEASE SPECIAL AUTHORIZATION FOR MINORS

I, _____, authorize the following name person/persons to authorize (Medical/Dental) treatment for my child/children by this facility.

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 this facility in writing regarding termination and effective date.

NAME OF PERSONAL REPRESENTATIVE	**RELATIONSHIP**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

NAMES OF CHILDREN	**AGES**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Signed by: _____

Relationship to child: _____

Date: _____