A Childrens Dentist

8710 W Charleston Blvd., Ste. 100

Las Vegas, Nevada 89117

(702) 255-0133 / Fax (702) 255-8374

Jacob Ozuna, D.M.D.

Date:___________________________

To Whom It May Concern:

This letter is to certify that
I____

Parent or Guardian of _________________________________give permission for
(child/children's names)
___________________________________to act in my behalf in making all medical
(must be over 18 years old)

And dental decisions for my child/children while under the care of:

Dr. Jacob Ozuna

This will include, but not limited to; changes in treatment plans, changes in cost estimates, and all medical emergencies for my child/children which may or may not be life threatening.

____
Parent or Legal Guardian

____
Date

State of Nevada County of ___________________. This instrument was acknowledged by ____________________on ___________________.

____
Notary Signature