Steven K. Olsen D.D.S., Professional Corporation

Curt C. Facchino, D.D.S.
H. Kashani, D.M.D., M.S., M.S
Albert Lam, D.M.D.
Shweta Prabhakar, D.D.S.
Darin T. Johnston, D.D.S.
Elham Shadmehr, D.D.S., M.S.
Russell S. Harris, D.D.S.
Nancy G. Loh, D.D.S.
Pil Han, D.M.D.
Michael Hwang, D.D.S.
Renzo Noratto, D.D.S.

TREATMENT AUTHORIZATION

Date: ____________________

Patient's Name: ____

Address: ____

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I hereby grant authority to Steven K. Olsen D.D.S., Professional Corporation, and or the dentist(s) in charge of my care, to administer treatment and such anesthetics as may be deemed necessary in the diagnosis and treatment of my case.

I acknowledge that I have been informed of possible risks and consequences of the proposed treatment and do authorize the above Doctor's to proceed.

Signed ____ **Date** ___________________

***Must be signed by <u>Patient, or Guardian</u> if the patient is a minor or if the patient is physically or mentally incapable.**

1/2024