Dental Power of Attorney

I,_____, designate_____
as my agent to make any and all dental care decisions for me. For the purpose of this document, "dental care decision" means consent, refusal of consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose, or treat an individual's dental condition.

Inspection and Disclosure of Information Relating to My Dental Health:
Subject to any limitations in this document, my agent has the power and authority to do all of the following:

1) Request, review, and receive any information, verbal or written, regarding my dental health, but not limited to dental records;

2) Execute on my behalf any releases or other documents that may be required in order to obtain this information;

3) Consent to the disclosure of this information.

Duration:
This power of attorney exists indefinitely from its date of execution, unless I establish herein a shorter time or revoke the power of attorney.

Alternative Agent:
In the event that my designated agent becomes unable, unwilling, or ineligible to serve, I hereby designate_____, as my alternate agent.

Location of Documents:
The original copy of this Dental Power of Attorney is located at Downtown Family Dental, 147 3rd Street, Baraboo, WI 53913.

Signed copies of this Dental Power of Attorney have been scanned in my dental records.

Patient's Signature: _____Date:_____