Daniel B. Levitt, D.D.S., P.C.
& Associates
160-34 Willets Point Blvd.
Whitestone, N.Y. 11357

AUTHORIZATION FOR HEALTH PROXY

I, _____, authorize the family members
PATIENT'S NAME (PRINT)
listed below to assist me with any communications or decisions relating to my dental/medical care and account with the office of Daniel B Levitt, DDS, PC..

1. _____ _____
NAME RELATIONSHIP

2. _____ _____
NAME RELATIONSHIP

_____ _____
PATIENT SIGNATURE DATE