AUTHORIZATION TO TREAT A MINOR PATIENT IN ABSENCE OF PARENT/ GUARDIAN

Minor patient name: _____ Date of birth: _____

Parent/ Legal Guardian's Name: _____

Home Phone Number: _____ Work Phone Number: _____

Cell Phone Number: _____ Other Phone Number: _____

I certify that I am the parent and/or legal guardian of _____
(Name of child)

☐ I authorize _____ to bring my child to office visits with Dr. _____
(name of person bringing child to office) (name of physician)

☐ I authorize the minor child named above to come alone to office visits with Dr. _____
(name of physician)
and I consent to the examination and/or treatment of my child.

This authorization:

☐ is effective on _____

☐ is effective from _____ to _____

☐ is effective until revoked by me in writing

I reserve the right to revoke this authorization at any time by writing to the above named physician.

Parent/ Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____