



INDIAN VALLEY PODIATRY ASSOCIATES, P.C.

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Authorization to Treat Minor Patient in Absence of Parent/Guardian

Name of minor patient: _____ Date of Birth: _____

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.

Parent/Legal Guardian Contact Information:

Home phone number _____

Office phone number _____

Cell phone number _____

Other phone number _____

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

Parent/Guardian Signature: _____ Date: _____