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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. _____________________ and
(name of physician

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: ________________