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AUTHORIZATION TO TREAT MINOR PATIENT IN ABSENCE OF GUARDIAN

PATIENT NAME: _____ DATE OF BIRTH: _____

PARENT/GUARDIAN NAME (printed): _____

PLEASE INITIAL EACH THAT APPLIES BELOW:

_____ I certify that I am the parent and/or legal guardian of the minor patient indicated above.

_____ I authorize _____ to bring my child to visits operated by the above-named medical practices. This person is authorized to make medical decisions on behalf of myself and my child. I will not hold the medical office responsible for medical decisions made in my absence.

PARENT/GUARDIAN CONTACT INFORMATION:

Home Phone _____

Cell Phone _____

Office Phone _____

Other Phone _____

This authorization is effective on the date of signing indicated below until revoked by me in writing. I reserve the right to revoke this authorization at any time by writing to the above-named physician or medical practice.

_____ _____

PARENT/GUARDIAN SIGNATURE TODAY'S DATE (EFFECTIVE DATE)