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 _____. I authorize
(Name of child)

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

and to 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: _____

Reviewed April 2008