AUTHORIZATION TO TREAT MINOR PATIENT IN ABSENCE OF PARENT/GUARDIAN

I, ______________________________ (name of parent), the parent and legal guardian of ______________________________ (name of my child),

hereby authorize ______________________________ (name of person bringing child to the office) to accompany my above-named child to office

visits with ______________________________ (name of physician or physicians) and to consent to the

examination and/or treatment of my child during the office visits.

This authorization:

☐ is effective only on ______________________________ (month/day/year).

☐ is effective -- never longer than six (6) months at a time –

from ______________________ (month/day/year) to ______________________ (month/day/year).

☐ 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.

____
SIGNATURE OF WITNESS

____
SIGNATURE OF PARENT/GUARDIAN

____
DATE

____
DATE

Rev. 5/01