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 certify that I am the parent and/or legal guardian of	(Name of Little
	(Name of child)
☐ I authorize to bring to bring to office)	ng my child to office visits with Dr
I authorize the minor child named above to come	alone to office visits with Dr
— I authorize the inmore time named above to come to	(name of physician)
and I consent to the examination and/or treatment of a	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 t	ime by writing to the above-named physician.
Parent/Guardian Signature:	Date: