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
(Name of parent/legal guardian)

of ________________________________.
(Name of child)

I authorize ____________________________* to bring my child to office visits with
(Name of person bringing child to office)

Dr. ______________________ and to consent to the examination and/or treatment of my child.
(Name of physician)

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:** _______________

*Authorized person must bring a valid photo ID to each appointment

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