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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:______________________________
(*Name of Child)*

I AUTHORIZE ______________________________ TO BRING MY CHILD TO OFFICE VISITS
(*Name of Person Bringing Child to Office*)
WITH DR. ____________________.
(Name of Physician)

I AUTHORIZE THE MINOR CHILD NAMED ABOVE TO COME ALONE TO OFFICE VISITS WITH DR.____________________ AND I 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.

PARENT/LEGAL GUARDIAN CONTACT INFORMATION:

HOME PHONE NO. ____________________ OFFICE PHONE NO.____________________

CELL PHONE NO. ____________________ OTHER PHONE NO.____________________

I RESERVE THE RIGHT TO REVOKE THIS AUTHORIZATION AT ANY TIME BY WRITING TO THE ABOVE-NAMED PHYSICIAN.

PARENT/GUARDIAN SIGNATURE:______________________________ DATE:____________________

LEGAL NOTICE/DISCLAIMER
The information contained in this document does not establish a standard of care, nor does it constitute legal advice. The information is for general informational purposes only and is written from a risk management perspective to aid in reducing professional liability exposure. Please review this document for applicability to your specific practice. You are encouraged to consult with your personal attorney for legal advice, as specific legal requirements may vary from state to state.

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