Foot & Ankle
Center of Arizona

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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:_____

Revised August 2017