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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.***