AUTHORIZATION TO CONSENT TO TREATMENT OF A MINOR

Patient's Name: ____DOB: ___________________

Parent or Guardian Name(s): ____

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If I am unavailable, the following person(s) have permission to bring my child in for their appointment(s) and have my consent to authorize any treatment that may be necessary for the minor's health and best interest. Please note that the person bringing your child in will be required to show their ID.

____Relationship: ________________

____Relationship: ________________

____Relationship: ________________

I understand that this consent will stay on file unless I change my mind and withdraw the consent sooner in writing.

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Signature of person who is granting authority to consent

____ Date: ________________

Relationship to minor