

AUTHORIZATION TO CONSENT TO TREATMENT OF A MINOR

Parent or Guardian Name(s):	Patient's Name:	DOB:
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.	Parent or Guardian Name(s)	
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:	their appointment(s) and hancessary for the minor's l	ave my consent to authorize any treatment that may be health and best interest. Please note that the person
Relationship:Relationship:		Relationship:
I understand that this consent will stay on file unless I change my mind and withdraw the consent sooner in writing. Signature of person who is granting authority to consent		Relationship:
Signature of person who is granting authority to consent		Relationship:
	I understand that this consent consent sooner in writing.	will stay on file unless I change my mind and withdraw the
Date:	Signature of po	erson who is granting authority to consent
Relationship to minor	Relations	