

**AUTHORIZATION TO TREAT MINOR PATIENT  
IN ABSENCE OF PARENT/GUARDIAN**

I, \_\_\_\_\_, the parent and legal guardian of \_\_\_\_\_,  
(name of parent/guardian) (name of child)

hereby authorize \_\_\_\_\_ to accompany my above-name child to  
(name of adult accompanying child to office)

office visits with \_\_\_\_\_ and to consent to the examination  
and/or  
(name of physician or physicians)

treatment of my child during the office visits.

This authorization:

is effective only on \_\_\_\_\_.  
month/day/year

is effective from \_\_\_\_\_ to \_\_\_\_\_.  
month/day/year month/day/year

is effective until revoked by me in writing.

I reserve the right to revoke this authorization at any time by writing to the above-name physician.

I understand that my child (under 18 years of age) cannot attend his/her appointment without the accompaniment from the adult listed above.

\_\_\_\_\_  
Signature of Parent/Guardian      Date

\_\_\_\_\_  
Signature of Witness  
or Notary Public      Date