Authorization to Treat Minor Patient in Absence of Parent/Guardian

Name of minor patient: ________________________________ Date of Birth: _________________

I certify that I am the parent/legal guardian of ________________________. I authorize
(Name of child)

_________________________________ to bring my child to office visits with Doctors
(name of person(s) authorized to bring child to office)

Transfiguracion, Shin, Wells, Nguyen, and/or Scott and to consent to the examination and/or treatment of my child.

This authorization is effective:

- ☐ on ______________________.
- ☐ from _____________________ to _______________________.
- ☐ until revoked in writing by me.

I reserve the right to revoke this authorization at any time by writing to the above named physician(s).

Parent/Guardian Printed Name: ____

Parent/Guardian Signature: ____________________________________ Date: ___________________

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