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 ________________________________. I authorize
(Name of child)

_____________________________ to bring my child to office visits with Drs. Wells, Noeller, and Transfiguracion
(name of person bringing child to office)

and to consent to the examination and/or treatment of my child.

This authorization:

☐ is effective on ____________________________.

☐ is effective from __________________________ to ____________________________.

☐ is effective until revoked by me in writing.

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

Parent/Guardian Signature: _______________________________________ Date: _______________

Witness Signature: ____ Date: _______________