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## Authorization to Treat Minor Patient in Absence of Parent/Guardian

I, \_\_\_\_\_ (name of parent/guardian), the parent and legal guardian of  
\_\_\_\_\_ (name of child), hereby authorize \_\_\_\_\_,  
(name of adult accompanying child to office) to accompany my above-named child to office visits with  
\_\_\_\_\_ (name of physician/physicians) and to consent to the  
examination and/or treatment of my child during the office visits.

### This authorization:

Is effective only on \_\_\_\_\_ (month/day/year)

Is effective from \_\_\_\_\_ to \_\_\_\_\_ 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 named 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

\_\_\_\_\_  
Date

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