Authorization for Treatment of Minors

Date: _____

Child(ren) Name	Date of Birth

I authorize medical treatment for the above listed child(ren) when the following adults bring my child(ren) to the office:

Name	Relationship

I understand that the above listed adults must be over 18 years of age and will be required to show photo ID at the visit.

□ My child(ren) is/are 16 years old of age or older and may transport themselves to appointments. I authorize medical treatment for the above listed child(ren) when not accompanied by a parent, guardian, or authorized adult.

This authorization remains in effect until the office is notified in writing by the parent or guardian.

_____ _____

Parent/Guardian PRINTED NAME Date

_____

Parent/Guardian Signature