Patient's Name:_________________________________ Date of Birth: ________________

Parental Authorization to treat Minor Child when not accompanied by Parent or Guardian

(This authorization is for patients under 18 years of age)

We must have permission from a child's parent or guardian before providing medical services when the child is accompanied by someone other than the parent or legal guardian or presents by him or herself. If you feel there may be an occasion where your child will be brought by a relative, sitter, etc., please fill out the following information for us to include with your child's records.

The following person(s) have my permission to authorize medical care for my child and sign any necessary waivers on my behalf.

Name	Relationship		Name	Relationship

May we phone, email, or send a text to you to confirm appointments? YES NO
May we leave a message on your answering machine at home or on your cell phone? YES NO
May we discuss your medical condition with any member of your family? YES NO
If YES, please name the members allowed:
____
____
____

For patients 16 years and older ONLY:

Yes____No____ patient listed above may present and be treated unaccompanied by an adult.

Signature of Parent
or Legal Guardian _______________________________ Date____________________