

# AUTHORIZATION FOR EXAMINATION AND/OR TREATMENT OF A MINOR

I, \_\_\_\_\_, the parent and/or  
(name of parent)

legal guardian of \_\_\_\_\_, hereby  
(name of child)

authorize \_\_\_\_\_  
(name of person bringing child to the office)

to accompany my above-named child to office visits with:

\_\_\_\_\_  
(name of physician or physicians)

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

This authorization:

is effective only on \_\_\_\_\_, 20 \_\_\_\_.

is effective from \_\_\_\_\_ 20 \_\_\_\_ to \_\_\_\_\_ 20 \_\_\_\_.

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.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness