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

____
(*Name of child)*

☐I authorize _________________________ to bring my child to office visits with Dr.
(name of person bringing child to office)

Christopher C. Mason, D.P.M. and I consent to the examination and/or treatment of my child.

☐I authorize the minor child named above to come alone to office visits with Dr. Christopher C. Mason, D.P.M. and I 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.

Parent/Legal Guardian Contact Information:

Home phone number ____________________

Office phone number____________________
Cell phone number _____________________

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:______________