St. Elizabeth PHYSICIANS

AUTHORIZATION TO TREAT MINOR IN ABSENCE OF PARENT/GUARDIAN

I, _____, the parent and/or legal guardian
(Name of parent/guardian)

of _____, date of birth _____, hereby
(Name of patient) (Patient)

authorize_____ to accompany the
(Name of person bringing patient to the office)

above-named patient to the office for visits with _____
(Name of physicians)

and do consent to the examination and /or treatment of the patient during the office visits.

This authorization:

- Is effective ***only*** on _____
(month / day / year)
- Is effective from _____ to _____
(month / day / year) (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.

_____ _____
SIGNATURE OF PARENT/GUARDIAN SIGNATURE OF WITNESS

_____ _____
DATE DATE