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 _____

Please check all that apply:

- o I authorize _____ to bring my child to office visits.
- o I authorize the minor child named above to come alone to office visits.
- o I consent to the examination and/or treatment of my child.
- o Verbal consent was obtained from _____ (relationship to child) _____.

Parent/Legal Guardian Contact Information:

Home Address: _____

City, State & Zip: _____

Cell Phone: _____ Fax: _____

I reserve the right to revoke this authorization at any time by notifying VFASA in writing.

Parent/Guardian Name: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____