# 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.

**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: _____________