www.illinoisfoot.com (847) 639-5800

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
(Name of Person Bringing minor to office)

Dr. ____________________________________ and I consent to the examination and/or
(Name of Doctor Treating Child)
treatment of my child.

This Authorization:

- ☐ Is effective on____
  (Date of Appointment)
- ☐ Is effective from ___________________________ to ___________________________
  (Date) *(Date)*
- ☐ Is effective until revoked by me in writing.

Parent/Legal Guardian Contact Information:

Name:____________________________________ Relation to Minor:___________________

Home Phone Number:______________________ Cell Phone Number:______________________

Parent/Guardian Signature:________________________________ Date:__________________