



NORTHERN ILLINOIS FOOT & ANKLE SPECIALISTS
113 W. Main Street, Cary, IL 60013
165 N. Lakewood Road, Suite A, Lake in the Hills, IL 60156

**Authorization to Treat Minor Patient in Absence of
Parent/Guardian**

Name of minor patient: _____ DOB _____

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
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 _____ Other phone number _____

I reserve the right to revoke this authorization at any time by writing to the above-named
physician.

Parent/Guardian Signature: _____ Date: _____