The Physician Network

AUTHORIZATION FOR EXAMINATION AND/OR TREATMENT OF A MINOR

I, _____, the parent and/or legal guardian
Printed Name of Parent or Legal Guardian

of_____, _____
Name of Child (patient) Date of Birth

hereby authorize _____, _____
Name of person bringing child to the office Relationship

and/or _____, _____
Name of person bringing child to the office Relationship

and/or _____, _____
Name of person bringing child to the office Relationship

To accompany my above-named child to office visits with:

_____
Name of provider(s)

And consent to the examination and/or treatment of my child during the office visits.

This authorization:

☐ Is effective only on:_____, 20_____.

☐ Is effective from:_____, 20_____ to _____, 20_____

☐ Is effective until revoked by me in writing.

_____ _____ _____
Signature of Parent/Next of Kin Date Time

_____ _____ _____
The "Physician Network" witness Date Time

_____ _____ _____
Second "The Physician Network Witness"— if telephone consent Date Time