AUTHORIZATION TO TREAT MINOR

PATIENT NAME: _____ DOB: _____

LEGAL GUARDIAN / PARENT: _____

ADDRESS: _____

PHONE NUMBER (PARENT / GUARDIAN): _____

I authorize Lee Family Practice Associates to provide medical treatment to the patient listed above, as I am not available to attend the appointment(s).

Check all that apply:

____ The patient is of driving age and will attend appointment(s) by his or her self.

____ The patient will be brought by someone other than myself. I have appointed the following person(s) that have permission to bring the patient to the appointment(s).

Name: _____ Relation to Patient: _____
Name: _____ Relation to Patient: _____
Name: _____ Relation to Patient: _____

The person(s) above MUST show Photo ID at the time of check-in

I understand that by signing this authorization, medical care will be provided to patient without my attendance of appointments. I understand that this authorization expires one year from the date of signature, unless I revoke by written consent.

_____