Parental Authorization for Medical Services

Patient Name: _____

DOB: _____

Parent/Guardian: _____

□ Parent □ □ Legal Guardian

Physician: □ _____

Date: _____

Please mark (✓) appropriate option(s):

□ I hereby give authorization for my child to be seen by the physician without a parent or legal guardian present. This authorization includes authorization to perform any diagnostic, surgical, non-surgical and other necessary services as deemed appropriate by the treating physician and/or his employed license/un-licensed healthcare professionals.

□ I authorize the physician to do a medical examination and perform appropriate non-invasive treatment, including x-rays, and report the findings and treatment plan to myself and any other authorized friends or family as expressly consented by me.

_____

Parent/ Legal Guardian's Signature & Date