Authorization to Treat Minor

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 the doctors of Rappahannock Foot & Ankle Specialists

- ☐ I authorize the minor child named above to come alone to office visits with the doctors of Rappahannock Foot & Ankle Specialists

- ☐ I/We, the Parent and/or Legal Guardian will be the only one to bring the child named above to office visits with the doctors of Rappahannock Foot and Ankle Specialists

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: _____________________ Office Phone Number:__________________

Cell 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: ________________

Witness Signature: ____ Date: ________________