PANEPINTO PODIATRY
FOOT MEDICINE & SURGERY

Authorization to Treat Minor Patient In Absence of Parent or Legal Guardian

I, _____, the parent or legal guardian of_____ _____, hereby
(parent) (name of patient)

authorize_____ _____ to accompany my above-named child to office visits with
(name of person bringing child)

_____ and to consent the examination and/or treatment of my child.
(physician)

This authorization:

- ☐ Is effective on _____
- ☐ Is effective from _____ to _____
- ☐ Is effective until revoked by me in writing.

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

Witness signature _____ Date _____

Parent/Legal Guardian _____ Date _____

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